Department of Social Work

International Masters of Science in Social Work

SWEDEN'S DILEMMA:

The Right to Health for Irregular Migrants

An examination of human rights law and factors affecting policy

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TABLE OF CONTENTS

TABLES

INTRODUCTION

Human rights are pledged to all; universal and inalienable, secured by the simple fact that we are human beings. However, despite this assurance, migrants, and especially irregular migrants, find themselves faced with a want for viable means of claiming their entitlements. They are disconnected from regular society, outside of the existing welfare system, and are faced with significant challenges to access of basic social services owing to their status. Consequently, irregular migrants are an especially vulnerable group; a group that is becoming ever more significant. According to the Platform for International Cooperation on Undocumented Migration (PICUM, 2012), there are an estimated 5 to 8 million irregular migrants in Europe. An earlier disregard of the group by the state at all levels, from politicians and policymakers to social workers and other public services providers, is becoming increasingly difficult to justify.

The right to health is a right affirmed to everyone under a variety of legally binding human rights documents within international law, most notably the *International Covenant on Economic, Social and Cultural Rights* (ICESCR), as well as regional and domestic legislation. At the same time though, the state ordered system reveals that states need not treat citizens and non-citizens alike. States continue to enjoy a degree of discretion where non-citizens are concerned (Rodriguez & Rubio-Marin, 2011).

The Swedish government provides only limited health services to irregular migrants, for which they have been highly criticized. In Sweden, irregular migrants are entitled to 'immediate' health care only and are required to pay the full cost of the services.[1] Yet, the accessibility of even this level of care has been deemed problematic for a variety of reasons. Evidently, irregular migrants fear the consequences of making themselves known to the authorities and the risk of deportation, while many are simply not informed of their right to access such services. Research has furthermore discovered inconsistencies in knowledge of the rights of irregular migrants by health care staff; refusal of service and discrimination by some health care staff where a legal identification card is not available has been noted in some cases (Baghir-Zada, 2009). In contrast to Sweden, a number of European nations offer varying, yet notably more comprehensive, health services to irregular migrants ranging from accessible emergency services to extensive health care including primary and secondary care.

It is assumed that international human rights law operates on a system of hierarchical rights by which the sovereign nation state's right is at odds with the rights of irregular migrants. Despite the affirmations of the UN General Assembly's 1993 Vienna Declaration, which states 'that the human person is the central subject of human rights and fundamental freedoms,' (UN General Assembly, 1993) international human rights cannot not only be represented by a moral desire for equal treatment but must be associated with a means of enforcement (Dembour & Kelly, 2011). The state, as the signatory of international human rights treaties, is responsible for ensuring that the human rights of individuals are upheld within their territory. Generally though, the majority of states see irregular migration as an affront to their sovereignty and therefore reject the provision of services to irregular migrants on the basis of this principle.

[1] This does not apply to children under the age of 18 years. Irregular child migrants may access health care to the same level as that of citizens.

Aside from the legislative challenges, the UN human rights system has nevertheless demonstrated a strong commitment towards encouraging State Parties to go beyond the strictly legal obligation to provide irregular migrants with the right to health on an equal basis as citizens and regularized residents. The UN often relies on political pressure, or the so-called *shame-game,* as it lacks an effective enforcement mechanism, particularly where the legal basis remains vague. Yet, whereas Sweden is globally praised for its human rights record, its strong welfare system, and its generous immigration policy, the Swedish Government has chosen to stand firm in its resolve that irregular migrants should only access emergency health care at their own unsubsidized expense. It was only until very recently that a decision has been proposed by a Government Inquiry (Swedish Board of Health and Welfare, 2011) to develop a scheme by which irregular migrants might enjoy health services on the same level as a citizen or resident as of January 1st, 2013. The conditions and mechanisms of this scheme are yet to be developed and therefore difficult to comment on the impact hitherto. Nevertheless, the wording of the Inquiry Report clearly outlines the strong position of the Swedish Government that the provision of social services to irregular migrants should not promote a sense of acceptance of irregular migration nor increase the number of irregular migrants coming to Sweden.

The first part of the paper will analyze the provisions for the enjoyment of the right to health for irregular migrants. Although the moral issues of the question are surely valuable, this paper will limit its focus to an examination of the legislative requirements placed of State Parties. The report considers international and regional human rights law, as well as Swedish domestic legislation.

The second part of the paper will examine a range of factors that can be considered to influence a state's health care policy as it applies to irregular migrants. The examination of factors will be undertaken through a comparative analysis with five other European states, who offer varying degrees of health care services to irregular migrants within their borders. The role of the welfare state, immigration policy and the shadow economy will be examined, alongside the number and type of irregular migrants, as well as the overall perception of irregular migration by governments and in public opinion.

The paper thus aims to answer two questions. Firstly, is the Swedish Government bound by international human rights law to assure the enjoyment of the right to health for irregular migrants within its territorial borders? Secondly, what are the primary factors that influence State health care policies for irregular migrants?

PROCESS

The author has taken a variety of resources into account in order to carry out the analysis and formulate conclusions.

The results presented in the first part of the paper are derived from an extensive review international, regional and domestic legal documentation. A review of international human rights treaties, including declarations, covenants/conventions, as well as treaty body interpretations in the form of general comments and periodic review documentation, was performed. The regional legislation of both the Council of Europe (CoE) and the European Union (EU) was furthermore assessed. An examination of the obligations presented through membership to the CoE was

conducted, including a review of convention and charter legislation, as well as statements of relevance by the Parliamentary Assembly. The same was conducted with the EU legislation, counting pertinent Directives and other recent developments in regards to immigration policy and irregular migration in particular. Finally, the applicable Swedish domestic law was reviewed. Sources for the section include the United Nations (UN) specialized agency websites, CoE and EU websites, books and journal articles referencing legal documents, Swedish Government websites, including *Migrationsverket* (Swedish Migration Board), as well as other sources providing versions of existing legislation. In some cases, English versions of the Swedish law were available on the government websites. However, where an English version was not available, a Swedish speaking lawyer assisted with the translation.

In addition, a broad appraisal of sources on the issue of the right to health for irregular migrants in Sweden and other European nations, together with an examination of issues related to human rights and migrants in general, was conducted in order to analyze the potential factors affecting policy. An evaluation of both regional and national immigration policies, the shadow economy and other factors deemed to impact state policy was furthermore effected. Efforts were taken to gain a wide understanding of various perceptions and positions regarding the overall discourse relating to the topic. Furthermore, a review of country specific statistical data on different immigration and economic indicators was conducted, including demographics and asylum application figures, as well as economic sector size, shadow economy data, and migrant employment figures. Other resources included journal articles, books, government websites and reports, independent migration project reports, as well as non-governmental and human rights advocacy agency reports and published statements.

As regards to the second component of the paper, a comparative analysis is utilized to consider the potential factors influencing policy. A total of five European countries were chosen for the comparative analysis, including Denmark, Norway, France, Spain and the Netherlands. Denmark and Norway have been selected due to their commonalities to Sweden, including their geographical proximity and immigration history and policy, strong welfare states, and social democratic tradition. France, Spain and the Netherlands offer are good comparison as nations with differing historical backgrounds, all with colonial pasts and prominent European immigration destinations. All five States offer the analysis a variety in the type and number of migrants, immigration policies and control mechanisms, as well as their response to irregular migrants' rights by which to compare the Swedish position.

As the nature of irregular migration assumes a degree of hiding and a life outside of the established society, researching the topic is particularly challenging and has proven difficult to gain concrete information on the issue. Due to the difficulties in accessing comparable data sources and information on irregular migration, it was decided to restrict the comparative analysis to six countries of which an acceptable amount of information was available for the analysis.

ETHICAL CONSIDERATIONS

The discourse on irregular migration includes a wide-ranging terminology. The paper refers to irregular migrants, as opposed to other available terms including illegal, undocumented, clandestine, or aliens rather than migrants. The reasons explaining the choice of terminology is discussed under the Irregular Migration heading. Regardless, it is

important to note that no term is perfect and all carry a degree of assumption. The choice of *Irregular* and *Migrant* has been taken with due consideration and has been measured as the most appropriate for the research questions at hand and the intended neutral approach of this paper.

The paper does not attempt to address the moral issues of the right to health for irregular migrants. While irregular migrants merit consideration of this aspect, the discussion is beyond the scope of the research questions of this paper. It is expected that the analysis presented in this paper can be complimented by existing sources dealing with the moral aspect for a comprehensive overview of the challenges presented towards both irregular migrants and states in relation to the right to health.

It is often challenging to discuss the topic of immigration without engendering sensitivities amongst readers' in respect of discussions that may be presumed either positive or negative in nature. Furthermore, the available literature and overall discourse on the topic of irregular migration tends to exhibit a subjective position by the author, whether it be an academic, organization, or government. As such, consideration of the biases in the research sources was measured throughout the analysis. The approach to this paper aims to present an objective position. The author does not intend to take a position on the issue or make a submission of proposal to alter existing policies and practices, but rather aims to discuss the existing conditions.

THEORETICAL FRAMEWORK

A variety of theories have been utilized to assist in the evaluation of the research questions.

The paper considers an analysis of the notion of the human rights based approach. The approach is characterized by an agreement of the indivisibility of human rights and that every person is a rights-holder by virtue of existence. The concept furthermore implies obligations on states to respect, protect and fulfill the human rights of everyone (UNFPA, 2012). The discrepancies between the human rights based approach and the practical reality of barriers to the enjoyment of human rights for irregular migrants is reflected upon at all stages of the analysis, however is particularly relevant to the examination of the first research question.

The role of path dependency is considered in the analysis of the second research question regarding the factors influencing health care policies for irregular migrants. Path dependency theory considers how a decision restricts future available options to a point that it subsequently supports the continued preservation of the initial decision (Hansen, 2002). A common criticism of path dependency theory is that it simply highlights the importance of history (Slagter, 2003), however Levi (2007 cited in Hansen, 2002) states that it is not the case. Levi claims that 'Path dependence has to mean, if it is to mean anything, that once a country or region has started down a track, the costs of reversal are very high.' Path dependency is therefore a useful theory in considering the impact of the historical background of states, including political ideology, welfare state development and immigration policy, on the current trends of immigration policy and the attribution of social rights to irregular migrants.

The concept of political ideologies, including liberal, social democratic and conservative regimes (Arts & Gelisse, 2002), are also considered, particularly in regards to the potential influence of the welfare state and immigration policy.

The application of game theory, i.e. a theory of social interaction (Prosch, 2003), is especially relevant to the evaluation of the second research question. The theory was utilized for both the identification of the potential factors that might affect state policy, as well as the detailed examination of the factors. For our analysis, the state is a player in the game setting in which the actions of the other players, including the general voter population, civil society, the UN, the EU and the CoE, and the irregular migrants themselves, influence its decisions. The State is required to evaluate the range of perspectives and act accordingly. For instance, the voting population's public opinion will influence future voting patterns and therefore is of importance for the current state agent. The public opinion is dynamic and ever evolving, yet remain the foundation of the decision making process of democratic states. The UN will furthermore set the stage for the degree in which the State can take liberties in the interpretation of the law before critical statements are likely to be made and the shame critique begins. The State must determine what level of critique it is ready to accept and at one point it might contemplate making concessions. Similarly, the State shall consider the legal obligations and position of the EU and the CoE. Civil society may act as the UN; however likely from a more grassroots perspective. These players have the potential to spark the interest of the voters; hence the State is required to consider their influence. Finally, the irregular migrant in the States' eyes should not be encouraged to remain in an irregular situation, yet their vulnerability as a group cannot be ignored. All actions and circumstances surrounding the other players' choices impact the State's decision. At the same time, the situation is not stagnant but rather ever evolving, thus necessitating adjustments in the State's position related to the movements of the other players. The State plays the game of attempting to juggle all of the varying perceptions yet aims to achieve its own goal.

1. MIGRATION, IRREGULAR MIGRATION AND THE RIGHT TO HEALTH

1.1 Migration Context

The world's population is becoming increasingly mobile, with an estimated 214 million migrants in 2010, a rise from another estimation of 191 million migrants in 2005. Furthermore, there were an estimated 15.4 million refugees and 845,800 asylum seekers globally in 2010 (IOM, 2011). The implications of such mobility have benefits and concerns to both sending and destination countries. Yet with the growth of globalization, we have seen developed nations activate progressively restrictive migration policies with a chief effort to tighten up borders (Kalm, 2010). Domestic immigration policy and international and regional cooperation on migration have become top priorities worldwide.

International cooperation on migration, with the exception of the refugee regime, has been largely resisted by nations. However, faced with increased globalization there have been a number of efforts to improve in this regard, including the consultative process of the Global Forum on Migration and Development (GFMD) and the Intergovernmental Consultations on Asylum, Refugees and Migration Policies (ICG), which is a think tank on migration control policies (Kalm, 2010), to name a few. Regardless, it is generally considered that cooperation on migration remains a lagging area of great importance.

The Schengen agreement of 1985, which established the free movement of individuals within the Schengen borders in Europe, required parties to the agreement to augment its collaboration. The establishment of common regulations of entry and stay, border police collaboration, and asylum procedures were necessitated (Lavenex, 2009). Efforts to realize the Schengen agreement was essentially the beginning of shared immigration policies and procedures amongst European States (Focus Migration, 2009). The responsibility for immigration was later transferred to the EU level competence in 1999, with cooperation amongst Member States progressively rising. At present, migration policy amongst EU and Schengen Member States is increasingly constituted by European level guidelines.

The EU has made migration and asylum one of their top priority policy initiatives (IOM, 2011). The Global Approach to Migration (GAM), adopted in 2005 and confirmed in 2006 by the European Council, is the strategic framework for the EUs common migration policy in external relations (Swedish Ministry of Justice, 2011). Its objectives are to promote relationships with third countries to support consistent migration policies, including labour migration and border control (IOM, 2011). A primary tool for managing migration in Europe is agreements with third countries.

Moreover, an agreement amongst EU Member States to harmonize asylum systems was agreed in 1999. The agreement to develop a Common European Asylum System followed in 2004 and is now a priority of the EU immigration policy, as set out in the Stockholm Programme. The policy is also a key target of the Swedish Government that is pushing for equal protection and shared responsibility amongst States. A number of legal instruments have already been established, most notably the Reception Conditions Directive (2003/9/EC)[2], the Dublin Regulation (2003/343/EC)[3] and the EURODAC Regulation (2000/2725/EC)[4]. The Stockholm Programme is furthermore focused on evaluating the implementation of the Return Directive (2008/115/EC)[5] and the Employers' Sanctions (2009/52/EC)[6] amongst EU Member States.

As is evident, the increased mobility worldwide has resulted in a shift in international relations regarding immigration. The EU is currently working with the logic of creating a common immigration policy that is said to meet four targets: 'organizing legal immigration better, enhancing integration of non-EU nationals in EU societies, managing migration through partnerships with non-EU countries, and curbing irregular migration' (European Commission of Home Affairs, 2012).

1.2 Irregular migration

Irregular migration is a legal construct; an individual may become irregular as a result of a violation of established policies regulating movement across national borders. The International Organization for Migration (IOM, 2004) defines irregular migration as 'movement that takes place outside of the regulatory norms of the sending, transit and

[2] Sets minimum standards for the reception of asylum seekers.
[3] Regulates which EU member state is responsible for examining an asylum application. The responsible state is most often the state through with the asylum seeker first entered the EU.
[4] A European-wide fingerprint database of unauthorized entrants into the EU. It is used in conjunction with the Dublin Regulation to form the Dublin System to identify and provide the transfer of asylum seekers to the EU state first entered.
[5] Establishes common procedures for the return of third country nationals with irregular statuses.
[6] Standardizes minimum sanctions, including prison terms for serious cases, against employers of irregular third country nations.

receiving countries.' At the same time, it is acknowledged that there is no collective agreement regarding the definition of irregular migration (IOM, 2004).

As alluded to above, irregular migration is a priority issue of European States by both the CoE and EU. The efforts to establish a common EU migration policy are considered to largely stem from growing fears of increased irregular migration amongst the EU Member States (Düvell, 2011). This is also evident in the CoE through its Parliamentary Assembly (2006) *Resolution 1509 on the Human Rights of irregular migrants'* whereby the first item states that European States are 'deeply concerned by the ever-growing number of irregular migrants in Europe.' Nevertheless, irregular migration continues to be under-researched (Triandafyllidou, 2011) and difficult to quantify, yet the complex notion involves facets of law, society and politics, by which it is highly influenced. Migration policies are driven by the political climate of perceived threats, such as security and lack of social cohesion (Lund Thomsen, 2010), leading the current European policy decisions towards increased controls with the aim of tackling irregular migration.

Few nations are able to accurately quantify irregular migration within their borders, whereas it also remains difficult to gain insight into the situation faced by irregular migrants as a result of their hidden nature in most contexts. An exception to this rule is observable in the case of Spain, in which the government keeps a registry of irregular migrants. However, this level of tolerance for irregular migrants though considered a rule in Spain (Gonzalez-Enriquez, 2010) is not generally common in other European nations. Notwithstanding, with the increased acknowledgement in recent years of the lack of a sound evidence-base in regards to irregular migration, a number of initiatives have been launched by the EU and individual nations in order to garner a better understanding of the situation. The projects include the *Clandestino Research Project* established by the European Commission,[7] the *Health Care in Nowhereland Project* focused on health for irregular migrants,[8] and the Norwegian governments' project of mapping irregular migration in Norway (Bak Jorgensen, M. & Meret, 2010), to highlight a few. Despite figures remaining *guestimates* to a certain degree, it is estimated that 1-4% of the population now living in Europe (Nowhereland, 2012), or 5 to 8 million people (PICUM, 2012), are in an irregular situation.

The pathways into irregularity are various and do not necessarily begin in irregularity, despite much of existing perceptions supported by both political and media campaigns. Instead, large proportions of the irregular migrants in Europe legally entered as tourists or on temporary permits and then overstayed and/or failed to have the visa renewed. Failed asylum seekers who choose not to return are also included in this group. Another facet of irregular migration includes unauthorized entries, either by way of smugglers, for employment or education, or as a means of family reunification, resulting in an irregular status. Moreover, trafficked persons also find themselves in irregular situations (Lund Thomsen, 2010). Regardless of the wide range of circumstances in which one might arrive at being irregular, a lack of a legal status is common to all, in addition to a vulnerability associated with their irregular status.

[7] Clandestino. Available at: http://clandestino.eliamep.gr/
[8] Nowhereland. Available at: http://www.nowhereland.info/

Other terms generally used synonymously with irregular migrants include illegal migrants, clandestine migrants, or undocumented migrants. As previously stated, each term entails certain implications, while many consider all to be insufficient. The term irregular migrant has been chosen for use in this paper as, in the same way as the CoE (2006) has determined, the term is more neutral and does not imply a criminality, as does the term illegal. Moreover, the term undocumented or '*papperslösa'* is considered to be inadequate despite its common use by civil society and academics (Baghir-Zada, 2009). In Sweden in particular, the terms undocumented migrant or *papperslösa* are commonly used, as well as *gömda*, which literally means hidden (Baghir-Zada, 2009). Undocumented implies that migrants are completely without papers, such as a passport or any other identification, rather than better defined as those lacking legal papers. Additionally, a clandestine migrant or '*gömda'* implies a secret or hidden status. While both terms may be well placed for usage in Sweden, as the majority of irregular migrants are rejected asylum seekers whose hidden nature confirms their status, it nevertheless does not recognize the heterogeneity of irregular migrants in the wider setting. A number of globally observed situations of migrants with an irregular status are not viewed in a manner that would imply the necessity for such secrecy. This will be of importance to the comparative analysis presented later. Finally, the term irregular best fits with the approach of this text, which intends to take a neutral point as regards to the examination of the issues from a legal and policy point of view rather than attempting to discuss the moral aspect of the dilemma.

1.3 What is the Right to Health?

The question of the right to health is particularly challenging as there is no clear definition of what constitutes health. The World Health Organization (WHO, 1946) Constitution defines health as '… a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.' The UN Committee on Economic, Social and Cultural Rights (2000) has stated that the right to health is highly dependent on the attainment of other rights, including food, housing, work, education and so on. The UN Special Rapporteur on the Highest Attainable Standard of Health includes the aspects of poverty and unemployment (Baghir-Zada, 2009), amongst others, as social determinants of health incorporated into the overall definition. All the same, as Baghir-Zada rightly points out with reference to the WHO Constitution, there is no all-inclusive understanding of the wording stated in these documents. What does mental health entail? Or what constitutes social well-being? The feeble, and sometimes contradictory, manner in which the right to health is exhibited in international human rights documents further compounds the confusion of what degree of enjoyment an individual is entitled.

The lack of a sound definition of the right to health is further complicated by the existing debate on the rights of irregular migrants. It is important to note that the debate as regards to the right to health for irregular migrants has largely been principally focused on the provision of health services rather than the broader definitions, as outlined above. The report will examine the contradiction as human rights advocacy efforts in relation to international human rights law on this discrepancy at a later stage. However, for the purposes of this report the discussion will refer to health care services in general unless otherwise specified, as this is largely where the current debate is concerned. With this in mind, the question regarding the level of health service is primary to the debate. Shall irregular migrants receive more than emergency care, and at what cost? Does the right to health imply preventative, curative and

palliative care as well? In the examination of the law and policies in relation to the criticisms against the Swedish Government by human rights advocates, the question of the degree of health will come into play.

2. INTERNATIONAL HUMAN RIGHTS LAW

The origins of the concept of human rights can be found in the historic philosophical discourse, as well as religious scripts that set out regulations for the conduct of society. The works discussed the concepts of equality, freedoms and justice within the rule of law, of which the Magna Carta of 1215 is an example. The French Declaration on the Rights of Man (1789), the United States Declaration of Independence (1776) and the American Bill of Rights (1791) followed later and entrenched the ideas of the great philosophers of the 18th and 19th centuries regarding the natural rights of human beings. This principle of inalienable rights proved to remain foundational to our understanding of human rights and would guide the development of contemporary human rights law (Smith, 2005).

Contemporary international human rights law can be said to have begun with the establishment of the League of Nations responsibilities for the protection of minority rights and the International Labour Organization's (ILO) mandate regarding workers rights. The League of Nations is said to have had little success in enforcing the human rights set out in the treaty agreements, yet it nevertheless set the stage for what would become the United Nations. The devastation of World War II reinforced States acknowledgement of the need for a mechanism of international protection, resulting in the founding of the United Nations (UN) in 1945. The Charter of the UN affirms its primary purpose to maintain international peace and security, while stating that the respect of human rights and fundamental freedoms is an essential precondition for its preservation (Smith, 2005). The UN Bill of Rights and the successive human rights conventions regulate the current international human rights doctrine.

2.1 The Right to Health in International Human Rights Law

The *Universal Declaration of Human Rights (UDHR)* (1948), though not legally binding, is a significant pronunciation of a global acceptance of universal human rights for all and acts as guidance in contemporary international human rights discourse. The declaration represents the standpoint following the end of World War II that the persecution of a people based on a specific distinction, whether it be by 'race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status' (UN, 1948, Art. 2) was unacceptable. However, like most of the conventions that follow the *UDHR*, there is no distinct reference to the rights of irregular migrants and therefore provides little guidance to States regarding the contradiction between universal human rights and sovereign nation rights.

The *UDHR* specifically acknowledges the right to health in Article 25.1 (UN, 1948), which states that:

'Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.'

The primary legally binding affirmation for the right to health however can be found in the *International Covenant on Economic, Social and Cultural rights (ICESCR)* (UN, 1966). More specifically, Article 12 indicates that the right to health entails both physical and mental health and makes mention of positive obligations of State Parties in regards to specific health issues. Just as the *UDHR*, the *ICESCR* emphasizes that all rights in the covenant are to 'be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.'

The right to health is also included in Article 5.e.iv of the *International Convention on the Elimination of All Forms of Racial Discrimination (CERD)* (UN, 1965) that states everyone's right to 'public health, medical care, social security and social services' and in Article 12 of the *Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)* (UN, 1979) which asserts the right to health care services on an equal basis for both men and women. The *Convention on the Rights of the Child (CRC)* (UN, 1989) reiterates the affirmation of the *ICESCR* yet specifically for children. Article 24.1 of the *CRC* guarantees the right to the 'enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health' for all children. Furthermore, States Parties are urged to 'strive to ensure that no child is deprived of his or her right of access to such health care services', while specific obligations by which the State Parties 'shall take appropriate measures' are highlighted in Article 24.2 a-f.

2.2 Interpretation and Applicability

The texts on the right to health in international human rights law presents a range of difficulties regarding interpretation and leaves much room for discrepancy. The terminology ranges from basic medical care to the highest standard of health, whilst at the same time failing to specifically address the challenge of irregular migration. In order to assist in the interpretation, a number of supplementary documents can be referenced, including relevant declarations and general comments that have been specifically formulated with this purpose.

In regards to the issues of regulating the rights of non-nationals, the *Declaration on the human rights of individuals who are not nationals of the country in which they live* (UN, 1985) proves relevant. The Declaration deals directly with the issue of migrants rights and although it is merely a declaration and therefore not legally enforceable, it highlights the dilemma. Much of the conventions reiterate a States right to determine the conditions of entry and stay within its borders, as well as to institute differences amongst nationals and *aliens*. The declaration states that migrant rights must be undertaken in line with the State's international obligations, including its human rights commitments. Of particular interest though, the declaration highlights the enjoyment of specific rights in relation to lawful residence and domestic law, whilst restricted rights for those in an irregular situation are outlined. In regards to the right to health, Article 8.1 confirms the 'right to health protection, medical care, social security, social services, …', however only for those 'lawfully residing in the territory of a State…in accordance with the national laws.'

General comments of relevance to irregular migrants include the *General Comment No.20* to the *ICESCR* (UNCESCR, 2009), which states that the 'Covenants rights apply to everyone including non-nationals, such as refugees, asylum-seekers, stateless persons, migrant workers and victims of international trafficking, regardless of legal status and

documentation.' In addition, *General Comment No.30* of the *CERD* (UNCERD, 2004) addresses discrimination in non-citizens. The General Comment states that while some rights may be confined to citizenship, such as voting in elections, 'human rights are, in principle, to be enjoyed by all persons.'

In response to the need for clarification on the right to health, the Committee on Economic, Social and Cultural Rights (UNCESCR, 2000) produced the *General Comment No.14 on the Right to the highest attainable standard of health* in the year 2000, which is the most comprehensive interpretation of the right to health available. In reference to Article 12 of the *ICESCR*, the Committee has affirmed that 'the right to health cannot simply be understood as a right to be healthy' and that it is 'closely related to and dependent upon the realization of other human rights…food, housing, work, (etc).' The Committee points to what it considers to be a general acknowledgement by the drafters of the *ICESCR* that the right to health encompasses a range of socio-economic factors and includes social determinants of health on the basis of Article 12.2 of the *ICESCR*. The General Comment goes on to ascertain State responsibilities in regards to the provision of *Availability*, *Accessibility*, *Acceptability* and *Quality* health to all and the obligations to *respect*, *protect* and *fulfill*. Finally, the General Comment also makes explicit mention of irregular migrants, eager to address the debate from a point of significant authority. The Committee notes that 'the obligation to *respect* the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including…asylum seekers and illegal immigrants, to preventive, curative and palliative health services...'

The general comments mentioned provide clarification regarding the degree of health, as well as specifically address the issue of irregular migration. Yet all general comments, while assisting in the interpretation, cannot be considered a legal obligation as they are not ratified by State Parties but are instead formulated outside of the strictly legal arena. Whereas general comments are often taken with serious considerations by the States of concern, States remain relatively free to make their own legal interpretation of the convention. Using general comments as a basis for an argument on the international scale may be relevant; however at the domestic level it remains ineffective.

2.3 Monitoring and Enforcement

The Special Rapporteur on the Right to the Highest Attainable Standard of Health has been provided a mandate to report on the global status of the right to health, including law and policies, as well as highlighting good practices and obstacles (UNOHCHR, 2002). The interpretation presented in *General Comment No.14* is the basis for much of the work of the Special Rapporteur.

In line with its mandate, the Special Rapporteur has nevertheless displayed some discrepancies in regards to the proposed application of the right to health. Most importantly for the purposes of this paper as noted by Baghir-Zada (2009), the Special Rapporteur advocates a meaning of health consistent with that of the *General Comment No. 14*, which includes the recognition of the social determinants of health with mention of poverty and unemployment as an example. Yet in spite of this conviction, the Special Rapporteur has only called on governments to provide health care services for irregular migrants. Albeit the fact that the call is for more broadened health services, including preventative and palliative care, the Special Rapporteur has not advocated for States to include provisions to address

the underlying social determinants of health that can be directly linked to the vulnerability of irregular migrants (Baghir-Zada, 2009). In this sense, the Special Rapporteur might be considered to promote the unequal hierarchy of human rights.

2.4 Dilemma: Right to Health and Irregular Migration

In acknowledgement of the challenges faced by migrant populations regardless of their status to the enjoyment of human rights, efforts to legally enshrine their rights have taken the form of the *Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families* (CMW, 1990). While other conventions aimed at protecting the rights of vulnerable groups have garnered much support, such as that for children and people with disabilities, the CMW has had very little success in this regard. In fact, at the time of writing, no western developed nation had ratified the convention, with the vast majority of the 45 signatories being sending, or emigration, nations (UN Treaty Collection, 2012). Despite the fact that no member of the EU has ratified the convention, political dynamics are so evident in the writing of this convention that it is worth a discussion. It is clear that the convention has been developed with the objective to meet the concerns of the industrialized nations in their fears of increased irregular migration linked to the provision of additional rights, including social services.

Specifically on the right to health, the CMW (1990) separates the rights of regular and irregular migrant workers. Article 28 affirms migrant workers and their families' right to receive 'medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health (…). Such emergency medical care shall not be refused them by reason of any irregularity with regard to stay or employment.' Part IV of the convention is specific to those migrant workers and their families' who are 'documented or in a regular situation'. Such regularized migrants are provided with access to social and health services on equal level to that of nationals of the country in which they live, as indicated in Article 43.1.e.

As such, the right to health for irregular migrants is once again set at emergency care only, with a clear discrepancy between the rights of regularized and irregular migrants. Even with the efforts of the Special Rapporteur and the interpretation presented by the Committee on Economic, Social and Cultural Rights in *General Comment No.14*, it is clear that the UN Member States have yet to come to an agreement on the degree of the right to health as applicable to irregular migrants. In fact, the CMW might even be seen as a step backward for advocates of the right in this regard.

2.5 The Conflict of the Sovereign Nation State

Contemporary international human rights law promotes the elemental UN principle of the recognition of the fundamental nature of human rights and the 'worth of the human person' (UN, 1945). Each convention developed throughout the history of the UN essentially reiterates the preamble of the *UDHR* (1948) that states the 'recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family.' However, it would be incomplete to discuss the implications of human rights without an acknowledgement of the ever present debate between universalism and particularism, which is especially relevant to the topic of this paper in regards to the rights of irregular migrants. On the one hand, human rights are generally acknowledged as being afforded to individuals on the

simple basis of the fact that they are human, thus universalistic and applicable to migrants regardless of their status. The Universalist view was further strengthened at the 1993 World Conference on Human Rights where State Parties agreed to the Vienna Declaration (UN, 1993) that emphasized not only the universality of rights but also the equal standing of all human rights. Nevertheless, the Particularists' view of the importance of the practical enjoyment one's individual human rights receives a good backing in relation to the complex dilemma facing irregular migrants. The difficulty of reconciling the human rights of individuals who possess an irregular status in the country in which they live is an ongoing challenge, with Noll (2012a) noting that irregular migration remains 'a foundational issue of contemporary law'.

Many of the critics of the Swedish governments' position on the right to health for irregular migrants, or the limited provision of rights to irregular migrants in general, is rooted in the belief that irregular migrants are entitled to enjoy all human rights based on a belief in the universality of human rights. Inalienable rights are rights for everyone, in the purest sense of the understanding. However, as much as it is morally correct to state that rights are universal, it would be irresponsible to ignore the certainty of the difficulties faced by both irregular migrants and States in resolving the question of the role of the state in the provision of rights. The balance of the sovereign nation right and universal human rights not only proves a problem for irregular migrants but, as Noll points out, it proves a problem for advocates of universal human rights everywhere (Noll, 2012b).

'The state-centered nature of international human rights law explains its inability to make the legal status in the nation state irrelevant.' (De Lomba, 2011)

The nation state is the signatory of international human rights law and they do so in their capacity as a State with responsibilities to the population within its territorial borders. International human rights law implies contact with the State in order for any individual to assert his/her entitlements (Noll, 2010b). The hidden status of an irregular migrant within society makes it difficult to challenge any violation and the lack of an effective legal framework addressing their rights presents a serious hindrance to effectually benefit from stating those rights (Baghir-Zada, 2009). It furthermore remains unclear how irregular migrants inalienable rights interact with the States rights to regulate and exclude based on their territorial sovereignty. While States do not claim that irregular migrants are not entitled to the enjoyment of universal human rights, they nevertheless reserve the right to refer the responsibility to ensure said rights to the State Party in which the irregular migrant has a regularized status. In that way, the State Party is within its sovereign rights to control the conditions of entry and stay within its territory (Noll, 2010b). Even the preamble of the *UDHR* (UN, 1948) emphasizes that human rights should be protected by the rule of law. The issue of the right to health is simply an example of the complex nature presented by irregular migration to the existing international human rights doctrine.

3. EUROPEAN CONTEXT: HUMAN RIGHTS LAW ON THE RIGHT TO HEALTH

The European system of human rights was developed in much of the same frame of mind as the UN, after the end of World War II at a time when Europe was struggling to rebuild (Smith, 2005). The CoE (2010a) established itself with ten Member States in 1949; it now has 47 Members States in Europe. The European Community was established soon

afterwards with a number of distinct communities including the European Economic Community (Smith, 2005), which were replaced by the EU through the Maastricht Treaty in 1992 (EU, 2012a). The EU currently has 27 Member States. The CoE and the EU both have mandates to promote human rights and the rule of law within a democratic structure in Europe (CoE, 2010c; EU, 2010). Sweden is member to both the CoE and the EU.

3.1 European Human Rights Legislation on the Right to Health

In 1953, the CoE's *European Convention for the Protection of Human Rights and Fundamental Freedoms* (CoE, 1950) came into force. The Council sought to institutionalize a concrete mechanism to realize the rights set out in the *UDHR*, which saw the establishment of a European Court of Human Rights (ECHR) in 1959. Unlike the UN system, the European system has a strong enforcement mechanism through the legally enforceable judgments of the ECHR that require States to make reparations to the affected claimant. Furthermore, the case-law enables the Convention to be consistently relevant to the evolving situation (CoE, 2012). A criticism of the Convention and the Court is that the rights to which it applies are primarily civil and political rights and thus fail to promote a comprehensive notion of human rights inclusive of economic, social and cultural rights.

The *European Social Charter* (CoE, 1996) aims to compliment the European Convention with regard to economic and social rights. The Charter furthermore has several provisions concerning the right to health. Article 11 articulates the right to protection of health including positive obligations of States to strive to eliminate causes of ill-health, to promote good health and to address issues of public health. In addition, Article 3 addresses healthy working conditions, while Articles 7 and 17 safeguards the health of children and young people, Articles 8 and 17 consider the health of pregnant women, and Article 12 concerns elderly persons health. In the most recent revision of 1996, Article 13 affirms the right to social and medical assistance, of which 13.1 obliges State Parties to 'that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition.'

In accordance with a statement by the Secretariat of the European Social Charter (1996) regarding the right to health and the European Charter, a series of positive obligations on State Parties articulate through the case-law relating to Articles 2 and 3 of the European Convention that deal with the right to life and the prohibition of torture respectively complement Article 11 of the Social Charter. Article 11 is said to include the right of every person to enjoy of the highest possible standard of health. The case-law further emphasizes that health care must be made accessible to the whole of the population, while it specifically makes reference to the right to health for children of irregular migrants. There is no relevant Articles or case-law relating to the right to health for irregular migrant adults however.

The Court of Justice of the EU (CJEU) and *the Charter of Fundamental Rights of the EU*, which is essentially similar to the CoE's ECHR, are additional mechanisms applicable to EU Member States which deal with human rights. The EU utilizes the CJEU to enforce an equal standard of human rights amongst its Member States. The enforceability of social rights and the rights of workers is particularly positive in the EU (Smith, 2005). Specifically in regards to health care, Article 35

of the EU Charter (2000) states that 'Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices.'

3.2 Irregular Migrants Rights in the European Human Rights Doctrine

The exclusion of irregular migrants is explicit in the European human rights law, as it largely points to an acknowledgement of the sovereign rights of States and conformity with national legislation.

The European States operate under a fear of mounting irregular migration, which it makes explicit reference in the first point of the CoE's (2006) *Resolution 1509 on the Human Rights of Irregular Migrants*. Whilst the Resolution acknowledges that international human rights instruments are applicable to irregular migrants, as well as notes the vulnerabilities faced by the group, it nevertheless affirms only minimum economic and social rights. In particular, Article 13.2 states that 'emergency health care should be available to irregular migrants and States should seek to provide more holistic health care, taking into account, in particular, the specific needs of vulnerable groups such as children, disabled persons, pregnant women and the elderly.' Article 14 moreover encourages States to ratify the CMW, which further reaffirms the right to emergency health only for irregular migrants.

As opposed to the UN system, the court system entrenched in EU human rights system means that there is the possibility for retribution where human rights violations are designated. Member States are required to alter national laws in order to be consistent with the relevant case-law. It furthermore means that the Conventions and Charters act as living documents that can be interpreted as required, resulting in equal measures of interpretation by all States. At the same time, it strongly recognizes sovereign nation rights (Smith, 2005).

4. SWEDISH LEGISLATION AND THE RIGHT TO HEALTH

The Swedish legislation concerning the right to health is consistent with that of the CoE and the EU, as is required of a Member State. In fact, the CoE's ECHR has been incorporated into the Swedish Constitution. Sweden has furthermore ratified the vast majority of the existing international human rights conventions, with the primary exception being the *CMW* (UN Treaty Collection, 2012). Moreover, Sweden converts its international and regional commitments directly into the national legislation, which reflects the States interpretation of its obligations.

The Swedish domestic legislation of concern to the right to health includes the *Hälso- och sjukvårdslag (1982:763)* (The Health and Medical Services Act), *Tandvårdslag (1985:125)* (The Dental Care Act), *Smittskyddslagen (2004:168)* (Communicable Disease Act) and the *Lag (2008:344*) *om hälso- och sjukvård åt asylsökande m.fl.* (Act on Health and Medical Services for Asylum Seekers and Others). The primary legislation regulating the conditions of entry and stay in Sweden is the *Utlänningslagen (2005:716)* (The Aliens Act), whereas the *Lag (1994:137) om mottagande av asylsökande m.fl.* (Act on the Reception of Asylum Seekers and Others) regulates the provision of assistance to asylum seekers and others. Also of relevance to the issue are the *Sekretesslag (1980:100*) (The Secrecy Act), *Lag (1998:531) om yrkesverksamhet på hälso- och sjukvårdens område* (Health and Medical Services Professional Activity Act), and the *Folkbokföringslag (1991:481)* (The Population Registers Act).

The *Health and Medical Services Act* and the *Dental Care Act* set the criteria of who is entitled to benefit from the Swedish national health care system. As the provision of health care is decentralized in Sweden, it is the County Councils who are entrusted with the responsibility of offering good health and medical care to both county residents and those who are not resident though are entitled to receive services in line with European Economic Area (EEA) policy. The law furthermore goes on to state that the County Council is responsible to provide 'immediate' health and medical services to those who are present but not resident nor entitled to care. Irregular migrants, alongside tourists, fall into to last grouping and must bear the full cost of the services. At the same time though, entitlement to care shall be provided regardless of one's ability to pay (Baghir-Zada, 2009).

In order to access health services in the county as a resident, one is required to register a relevant address with the Swedish tax authorities (*Skatteverket* in Swedish). The conditions for registering within the county require a personal number (*personnummer* in Swedish), which is a type of social security number that is used to access social services, amongst other things, that all formal residents of Sweden possess in accordance with the *Population Registers Act*. Irregular migrants do not generally acquire a personal number unless they are overstayers that had previously attained a number during their time with a regularized status (Baghir-Zada, 2009).

The *Act on the Reception of Asylum Seekers and Others* stipulates the circumstances for assistance for asylum seekers and others throughout their stay in Sweden. In particular, Article 11 affirms that the right to assistance ends when a permit to stay is provided or when the foreigner leaves the country. Article 12 follows to declare that any foreigner who keeps oneself away from a decision to or being deported has no right to assistance. Hence, irregular migrants are not entitled to assistance.

The *Act on Health and Medical Services for Asylum Seekers and Others* of 2008 reaffirms the right to services to same category of persons as in the *Act on the Reception of Asylum Seekers and Others*. Article 4 furthermore insists that the provisions are not to apply to foreigners who keep themselves away from a decision of deportation if they are older than 18 years of age. As such, the Act makes explicit provision for irregular children to access subsidized health services on an equal basis as Swedish citizens and regularized residents.

The *Secrecy Act* is relevant as it designed to safeguard personal information and ensure confidentiality, and it is applicable to irregular migrants. Although there are few exceptions, health care staffs are not required to report irregular migrants to the migration authorities. However, specific requests for information by police in cases where there are suspicions of crime, health care providers are allowed to provide information according to the *Health and Medical Services Professional Activity Act*.

4.1 Does Sweden meet its Obligations?

The analysis indicates that the Swedish Government's legal obligation towards irregular migrants is to grant emergency health care as per the international and regional human rights law.

Firstly, the right to health in international human rights law does not provide any clear definition of health or what the right to health entails, thus leaving room for interpretation of State Parties. In addition, international human rights law asserts the rights of the State to determine the conditions of entry and stay within their territorial borders, thus State's may refer the responsibility for irregular migrants back to the migrant's country of legal residence or origin. Whilst the interpretations of the law provided by the relevant Convention Committees prove much more extensive, including preventative, curative and palliative care, there are no means of legal redress available as the interpretations are merely indicative.

The European obligations, being more easily enforceable through established legal systems, define irregular migrants as having the right to emergency health care services, hence the Swedish Government's responsibility to comply. *Resolution 1509* of the CoE outlines the right to emergency services and links it directly to irregular migrants; therefore there is little uncertainty regarding State requirements.

Finally, the Swedish legislation affirms, in accordance with *Resolution 1509*, the right to 'immediate' care of irregular migrants. The definition of 'immediate' care remains a challenge, and there are reports of inconsistencies in the implementation of the Swedish legislation (Baghir-Zada, 2009), however in theory the Swedish Government meets its legal obligations towards the right to health for irregular migrants.

The conclusion is likely to be slightly controversial as a wide range of the literature and debate point to the fact that Sweden does not meet its international human rights obligations towards irregular migrants. However, as the report has attempted to highlight, the conclusion may vary depending on the approach to the analysis. While other papers have assented to the human rights based approach as a given, this paper considered the importance to question the reality of the implementation. The logic of this stance is rooted in the acknowledgement of the challenges presented by nation state sovereignty and the fact that, as Noll discusses (2010a), the current lack of enjoyment of rights for irregular migrants poses a vital question to the very notion of the universality and inalienability in the human rights discourse. Hence, the practical implementation of the human rights based approach is questionable, though commendable as an ideal by which to strive.

5. SWEDEN: FROM EMIGRATION TO IMMIGRATION

Sweden is not traditionally an immigrant nation. In fact, between the ends of the 19th century until approximately the 1920s an estimated one-fifth of Sweden's population emigrated, mainly to North America. Sweden's first significant group of immigrants in more than two centuries arrived in the 1940's in response to a need for industrial manpower. The requisite for this type of labour continued throughout the post-war era until the mid-1970s while the economy was thriving and there was a general need for unskilled labour across Western Europe. Throughout this time, the vast majority of the immigration came from within the Nordic community, which was facilitated by a common labour market agreement that allowed Nordic citizens to work and settle anywhere in the Nordic region, with the exception of Iceland who only joined at a later time (Lundberg Lithman, 1987). Finland was, and remains, the largest foreign born population in Sweden (Vasileva, 2011). As a result of the primarily Nordic immigration, Sweden remained relatively

homogenous in culture and language throughout the 1940s. Smaller groups of foreign workers began to come to Sweden either on their own initiative or via bilateral agreements for recruitment of foreign workers between the ends of the 1940s until the end of the early 1970s. The largest groups came primarily from Yugoslavia, Turkey and Greece. Sweden did not have an official guest worker policy during this time and immigration was essentially open until the end of the 1960s. However, as a result of increasing public and political pressure regarding the social and economic consequences of such free immigration, notably by trade unions that also highlighted issues of the rights and position of foreign workers, the Aliens Act was revised in 1968 to require all workers to have a work permit prior to entry (Lundberg Lithman, 1987).

In addition, a change occurred in the pattern of immigration to Sweden in the 1970s. The Swedish economy weakened and fewer Nordic immigrants arrived, although there was an increase in family reunification and refugees coming to Sweden. By the 1980s, the majority of immigrants in Sweden were refugees, with an increasing proportion from non-European countries (Lundberg Lithman, 1987). The focus of the Swedish immigration policy leaned heavily towards a humanitarian approach.

As of today, Sweden remains a nation of refuge for many who flee persecution or are in need of humanitarian protection. Sweden remains an important destination for asylum seekers, illustrated by the fact that the country received the fifth highest number of asylum applications amongst the industrialized countries in 2011 (UNHCR, 2012). Figures issued by the Swedish Migration Board for 2010 indicate that family reunification remains the largest group recipients of permits, making up 27% of all permits issued in 2010. EU/EEA citizens were the next largest group, at 20%, followed by visiting students, at 16%. Labour immigrants and permits issued for other labour market reasons also make up a significant proportion of permits given out in 2010, at 15% and 9% respectively. Refugees and persons in need of protection as a grouping accounted for the remaining 13% of permits issued (Swedish Ministry of Justice, 2011). Furthermore, the foreign-born population in Sweden as of 2010 represented 14.3% of the total population, of which 5.1% were from other EU nations while the remaining 9.2% came from non-EU nations (Vasileva, 2011).

6. AN EXAMINATION OF THE ISSUES

6.1 A Call for the Right to Health for Irregular Migrants in Sweden

Sweden has been characterized as one of the nations in Europe with the most restrictive policies regarding irregular migrants and their ability to access health services (PICUM, 2007). It should be noted that much of the criticism of Sweden regarding the right to health goes beyond the legal provisions into the actual realisation of the entitlements. The principle point of reference is the EU legislation on the right to health, which clearly establishes the State Parties' responsibility to provide only emergency health services to irregular migrants. As Swedish law provides for immediate care for irregular migrants, the criticism has ranged from the lack of access in regard to immediate care to the broader scope of the attainment of the right to preventative, curative and palliative health care services.

It is the national and international non-governmental organizations (NGOs), including many of those that work directly with irregular migrants in Sweden alongside human rights advocacy groups, that have brought much attention to the difficulties faced by irregular migrants in accessing health services in Sweden. One of the most prominent critics of Sweden's domestic legal, policy and institutional frameworks addressing the right to health has come from Mr. Paul Hunt, who visited Sweden in 2006 in his capacity as the UN Special Rapporteur on the Right to the Highest Attainable Standard of Health. In his mission report to the UN Human Rights Council, Hunt (2006) noted that the standard and quality of care available in Sweden is amongst the world's best, yet he denounced the exclusion of irregular migrants. Specifically, in point 72 of his report, he states that Swedish law does not conform to international human rights law in respect to the fact that Sweden is a signatory to a number of relevant international human rights conventions. The report then goes on to refer to the interpretation of the Committee on Economic, Social and Cultural Rights in the *General Comment No.14* as a substantiation of Sweden's obligations. Mr. Hunt subsequently called on the Government of Sweden to 'reconsider' its position regarding the provision of health care to irregular migrants in order to, in his opinion, bring itself in line with its international human rights obligations.

In February 2008, Paul Hunt again visited Sweden again to take part in a hearing regarding the development of the *Health and Medical Care for Asylum Seekers and Others Act*. At this time, Mr. Hunt reiterated his position regarding Sweden's stance on health care provision to irregular migrants (Baghir-Zada, 2009). Yet, regardless of his plea, irregular migrants remained outside of the provisions allocated by the Act when it came into force in 2008.

6.2 Health services for Irregular migrants in Sweden: Why Not?

The justification for the lack of willingness to provide health services to irregular migrants on the same standing as regularized residents and citizens are wide-ranging. They include negative as well as positive positions.

For Sweden, one of the primary reasons often stated in the discourse is the fear of encouraging irregular migration and implying an acceptance of irregularity (Alexander, 2010). The 2011 report, *Health care needs and on equal terms - A human right: Report of Inquiry on Health for undocumented migrants and others* (Swedish Board of Health and Welfare, 2011) states that the 'availability of medical services should not contribute to more people staying and working in Sweden without the necessary permits to stay in the country.' It goes on to say that 'increased availability of care should not be interpreted as increased acceptance of staying in the country without the necessary permits.' As such, the lack of provision of health care services beyond non-subsidized emergency care is a clear statement to irregular migrants by the government authorities; it is a punishment to those in an irregular situation and a means of deterring others. Further to this, the provision of health care services is considered an encouragement for irregular migrants to remain in the country (Alexander, 2010).

Of importance noted in the Swedish context is the issue of equity in the redistribution of social care. As Sweden's health care system is a publicly financed tax based system, restrictions to health care services are stated as a means of protecting the interests of those who pay taxes into the system. In addition, there are fears that allowing irregular

migrants equal service will put strain on the resources available within the national health care system, despite the fact that there is no real evidence available to support this claim at this time (De Lomba, 2011).

Finally, related to the interpretation of an acceptance of irregular migration, is the concern about the existence of a hidden segment of society and the exploitative opportunities that arise from such a status (Alexander, 2010). States do not want to be judged as accepting such vulnerable conditions for persons.

7. COMPARATIVE ANALYSIS

The wide-ranging policies across the European community illustrate a divergence either in interpretation of human rights law or merely the acceptance to provide accessible health services based on a moral conscience, an economic investment, or other factors. This paper will now continue with an examination of a variety of positions, perceptions and potential explanations that may impact on the position of States in this regard. Although irregular migration is a highly complex and dynamic issue, thus making it challenging to make exact conclusions regarding the divergence amongst European States, probable factors can nevertheless be identified as impacting a States' position. The report will particularly assess the possible rationale of the Swedish Government position until now, as well as analyze the potential reasons for the recent shift in position.

An article published by Björgren Cuadra (2011) discussed a similar topic as the second component of this paper. The article is brief and classifies States according to their health care policies towards irregular migrants. A number of factors influencing policy were raised, yet not extensively elaborated. This paper seeks to consider Björgren Cuadra's conclusions and conduct an in-depth independent review of a larger number of factors. In order to achieve this, the comparative analysis will focus on five European States.

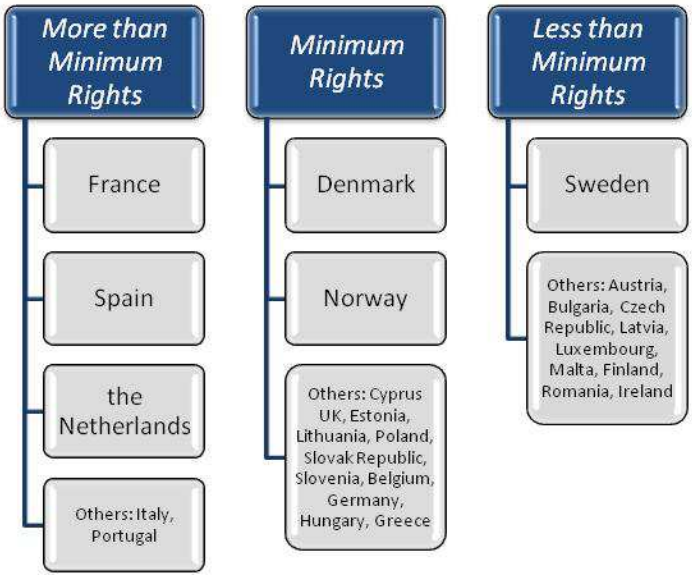
7.1 European Health Policy for Irregular Migrants

A research conducted by the *Health Care in NowHereland Project* (Karl-Trummer et al, 2010) has categorized European states into three clusters based on national health care policies related to irregular migrants via a human rights based approach. The clustering will be utilized for this paper, as it provides a criterion for categorizing that will assist the comparative analysis. This paper however will not consider all States in the *NowHereland* research but will instead focus on five States that have been chosen due to their relevance for comparison. The rational for the choice of the five European States is found in the Process section of the paper. It should be noted that Norway has not been included in all aspects of the *NowHereland* categorization as it is not an EU member state. Thus, other sources have been utilized to supplement the *NowHereland* results where necessary.

The categorization by *NowHereland* utilizes *Resolution 1509* of the CoE, which states that all states should provide at least emergency health care to irregular migrants, as the foundation of its categorization. The first cluster of States noted to offer *Less than Minimum Rights* are said to restrict health care to an extent that emergency care is not accessible. Secondly, *Minimum Rights* are where irregular migrants may access emergency care without discrimination based on their irregularity. Finally, the cluster of *More than Minimum Rights* refers to health care that goes beyond

emergency care, including primary care. Sweden has been placed in the *Less than Minimum Rights* cluster, with the justification that it is too difficult for irregular migrants to access emergency services. Denmark and Norway are positioned in the *Minimum Rights* cluster as they offer emergency services, whereas Spain, France and the Netherlands are placed in the *More than Minimum Rights* cluster, due to policies that provide access to more than emergency services.

The figure below illustrates the placement of our six countries for comparative analysis together with other European States classified in the *NowHereland* project.



7.1.1 Individual State Schemes

France's *Aide Médicale d'état (AME)* is an insurance scheme established in 1995 that is open to any migrant that does not meet the legal requirements to enroll in the *Couverture Médicale Universelle (CMU)*, which is a separate scheme to provide unemployed legal residents of more than three months with universal medical coverage. Both the *AME* and *CMU* have been formulated with the underlying principle of ensuring equitable access to quality health care for all. Both schemes are State funded. Irregular migrants must qualify to receive a certificate of the right to the *AME* that includes proving their identity and residence in France, as well as inadequate financial resources. The popularity of the *AME* scheme can be seen through its increased expenses, which grew by 17% between May 2009 and May 2010 (Duguet & Bévière, 2011). The increase resulted in mounting pressure to adjust the scheme, and after much debate, the legislation has recently been altered. Upon registration, each beneficiary is now required to pay a fee of 30 € per year for the service, with the exception of minors (République Française, 2011).

Spain is one of the European countries that provides the most comprehensive health coverage for irregular migrants (Björngren Cuadra, 2010a). The right to health care for irregular migrants in Spain is set out in *General Law 4/2000*, the Law of Foreigners (Clandestino, 2009a). Irregular migrants who register with their local census (*Padron Municipal des Habitantes*) are entitled to receive health care services equal to that of a Spanish citizen. The same is true for

unregistered irregular minors and pregnant women, whilst other unregistered irregular migrants are only provided emergency health care as required (Duguet & Bévière, 2011). In order to register with the *Padron*, the migrant must present a paper, such as an electrical bill or rental contract that indicates that the person is living in the municipal area, or can get a declaration from another person living in the municipality stating that they share housing (Clandestino, 2009a). The logic of the Spanish legislation is to assure health care service access to all (Björngren Cuadra, 2010a).

The Netherlands, the last country in our analysis placed in the *More than Minimum Rights* category, only recently changed its legislation to include more comprehensive health services for irregular migrants. The *Law on the Reimbursement of the Costs of Care for Illegal Aliens* came into effect in January 1st, 2009 (Björngren Cuadra, 2010b). Prior to that, the *Linkage Act of 1998* linked the right to health care services to a regularized status. However, the *Aliens Act of 2000* nevertheless indicated that irregular migrants were entitled to health care that is 'medically necessary' or where it is a concern to public health (PICUM, 2007). Instead, the current system makes the distinction between directly accessible services and non-directly accessible services rather than primary and secondary care. The new scheme requires that the service provider make the effort to receive payment from the patient, in the form of an invoice for example. It is only when the service provider can prove that the payment is not forthcoming can they apply for reimbursement of 80% of the cost of care. The onus is therefore placed on the service provider rather than the patient.[9] The State assumes the costs and the patient is not required to pay if they are unable to do so. It is generally assumed that most irregular migrants will not pay for the service (Björngren Cuadra, 2010b).

Both Denmark and Norway, being classified in the *Minimum Rights* cluster, offer emergency health care services to irregular migrants. In Denmark, emergency care is to be provided free of charge to all foreign persons temporarily in Denmark. The cost is borne by the State, or more specifically by the Ministry of Refugee, Immigration and Integration Affairs. Furthermore, minors in an irregular situation are entitled to extended care, including preventative care (Björngren Cuadra, 2010c).

In Norway, irregular migrants can access emergency care at the municipal primary health care centers, as well as specialised health care at hospitals and maternity wards but must pay for the service (Harslof Hjelde, 2010). Moreover, the legislation provides for 'necessary health care' for those temporarily residing in the country, which could be interpreted to provide more extensive services than emergency care, yet this remains debatable. Norway, like Sweden, is in the midst of an evaluation of the health services offered to irregular migrants (Oien & Sonsterudbråten, 2011).

Harslof Hjelde (2010) seems to point to the fact that the situation for irregular migrants in Norway and Sweden are quite similar in regards to the challenges to access even emergency services. Despite the similarities between the two systems, the *Nowhereland* project nevertheless placed Norway in the *Minimum Rights* cluster, which indicates that they do not consider the costs to hinder the access (Karl-Trummer et al, 2010). As such, for the purposes of our analysis, the report will consider the categorization from *Nowhereland* as a reference point for the examination of the factors affecting policies.

[9] Aside from costs related to pregnancy and childbirth.

Finally, as previously mentioned, Sweden has been categorized in the *Less than Minimum Rights* cluster. The logic of the classification is said to lie in the fact that the emergency health care services on offer are available at a cost that is not realistically accessible to most irregular migrants. According to Baghir-Zada (2009), the costs for irregular migrants are non-subsided and well above the costs for residents and citizens. For instance, a consultation with a doctor at an emergency department will cost a Swedish resident or citizen 260 SEK[10], yet it costs 2,000 SEK for a non-resident, i.e. irregular migrant. Irregular migrants, if they choose to access health care, are therefore more likely to present themselves to one of the voluntary clinics offering free services to irregular migrants. It should also be noted that specific counties, such as the Region Skåne, and hospitals, like the Sahlgrenska University Hospital in Gothenburg, have taken their own decision to offer subsidized or free care to irregular migrants.

8. FACTORS AFFECTING POLICY

The research has pointed to a number of potential factors that may impact the degree of health care services a State is ready to afford to irregular migrants.

The nature, including the total number and type of irregular migrants present in a country, has been considered to have a bearing on the issue. Furthermore, the historical background of immigration and the development and current trends of a nation's immigration policy, as well as the characteristics of the welfare state, are of interest to consider in our analysis. The role of informal work and the shadow economy are also of importance to the debate on irregular migration. Finally, the issue of public opinion will be assessed for its influence on the health policies of states.

Table 1 on the next page presents an overview of the relevant features of each country in our comparative analysis. The report will continue with a detailed analysis of each of the potential factors of interest.

[10] 900 SEK is the maximum fee for care to be paid during a 12-month period regardless of the type of care received.

Table 1: An overview of factors potentially impacting State health care policy for Irregular Migrants by Country

Country	Population (by 1000 persons) 2010[1]	Population of Non-nationals by Percentage of Total Population 2010[1,2]	Population of Foreign-born by Percentage of Total Population 2010[1,2]	Estimated # of Irregular Migrants[3]	Estimated Percentage Range of Irregular Migrants in Total Population	Immigration Policy Focus/Historical Background	Internal Controls	Pathways into Irregularity	Regularisation Programmes	Current Immigration Policy Trend
Sweden	9 340.7	6.3%	14.3%	15 000 - 80 000[3]	Low: 0.2% High: 0.9%	Traditionally not an immigrant nation High number of asylum applications Humanitarian basis	High	Primary: rejected asylum seekers Other: unauthorized entry; overstayers	No regularisation programmes Humanitarian grounds (case-by-case basis)	Increasingly restrictive
The Netherlands	16 575.0	3.9%	11.1%	60 000 - 225 000	Low: 0.4% High: 1.4%	Traditional immigrant nation in Europe Moderate number of asylum applications Labour migration & Colonial past	Moderate	overstayers, unauthorized entry Rejected asylum seekers, No clear agreement on primary group	Small scale regularisations Humanitarian grounds	Increasingly restrictive
France	64 716.3	5.8%	11.1%	300 000 - 500 000	Low: 0.5% High: 0.8%	Traditional & Primary immigrant nation in Europe High number of asylum applications Labour migration & Colonial past	Moderate	Primary: overstayers Other: rejected asylum seekers; unauthorized entry (less common)	Tradition of regularisations Economic and humanitarian grounds	Increasingly restrictive
Spain	45 989.0	12.3%	14.0%	150 000 - 700 000	Low: 0.3% High: 1.5%	Primary immigrant nation of Europe Low number of asylum applications Labour migration & Colonial past	Moderate-Low	Primary: overstayers Other: befallen, unauthorized entry Negligible: rejected asylum seekers	Tradition of regularisations Primarily aimed at irregular workers	Increasingly restrictive
Denmark	5 534.7	6%	9.0%	1 000 - 5 000[4]	Low: 0.02% High: 0.09%	Traditionally not an immigrant nation Low number of asylum applications Humanitarian basis	High	Primary: rejected asylum seekers Other: overstayers; unauthorized entry	No regularisation programmes Humanitarian grounds (case-by-case basis)	Restrictive
Norway	4 854.5	6.8%	10.8%	~18,000[5]	~0.4%[5]	Traditionally not an immigrant nation Moderate number of asylum applications Humanitarian basis	High	Primary: rejected asylum seekers Other: unauthorized entry; overstayers	No regularisation programmes Humanitarian grounds (case-by-case basis)	Increasingly restrictive

[1] Vasileva, K., 2011. 6.5% of the EU population are foreigners and 9.4% are born abroad. Eurostat Statistics in Focus, Population and Social Conditions, 34/2011 [Online]. Available at: http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-SF-11-034/EN/KS-SF-11-034-EN.PDF (accessed 24 April 2012)

[2] Includes Non-nationals who are citizens of other EU member states and non-member states

[3] Figures by Baldwin-Edwards & Kraler, 2009. In Björngren Cuadra, C., 2010. *Nowhereland: Policies on Health Care for Undocumented Migrants in EU27, Country Reports* [Online]. Work Package 4, Deliverable No. 6, Malmö Institute of Migration, Health and Society, Malmö, Sweden. Available at: http://files.nowhereland.info/692.pdf (accessed 24 April 2010)

[4] Figures by Wöger, 2009. In Björngren Cuadra, C., 2010. *Nowhereland: Policies on Health Care for Undocumented Migrants in EU27, Country Report: Denmark* [Online]. Work Package 4, Deliverable No. 6, Malmö Institute of Migration,

[5] Figure from Statistics Norway, 2006. In Harslof Hjelde, K., 2010. Irregular migration, health and access to health services in Oslo. In Lund Thomsen et al., ed. Irregular Migration in a Scandinavian Perspective. Maastrict: Shaker Publishing. Ch. 12.

8.1 Irregular Migration in Numbers

The nature of irregular migration poses significant restraints to acquiring concrete data on the total number of migrants. The issue is confounded by the fact that, as previously mentioned, the phenomenon was commonly ignored and remains under-researched even today, albeit with some improvements. At this point in time, numbers are often calculated using a variety of sources. Sources include, amongst others, figures of rejected asylum applications, expulsion orders, the number of foreigners apprehended without legal documentation, stays in detention, and any state social service registry for irregular migrants if available. The methods for calculation differ, whereas the indicators are dynamic and constantly changing. Regardless of the uncertainties, a range of estimates may nevertheless provide some insight into a States standpoint regarding irregular migration within its territorial borders.

The estimates of the number of irregular migrants in Sweden range from 10,000 to 80,000 persons. Baldwin-Edwards & Kraler (2009 cited in Björngren Cuadra, 2010d) estimated that there were anywhere between 15,000-80,000 irregular migrants in Sweden in 2009, whereas the Swedish Board of Health and Welfare put the estimate at 20,000 in their 2009 report (Björngren Cuadra, 2010d). Bak Jorgensen and Meret (2010) stated that there were about 50,000 irregular migrants in Sweden in their 2010 article, whereas the Swedish Board of Health and Welfare (2010) makes reference to two different sources in their 2010 Social Report: a general estimate of 10,000-35,000 and a high estimate of 30,000-50,000. The most recent Swedish Government reference can be found in the *Report on the Inquiry on Health for Undocumented Migrants and Others* (Swedish Board of Health and Welfare, 2011) which stays with the previous general estimate, placing the figure of irregular migrants at approximately 10,000-35,000 each year.

In absolute numbers, the number of irregular migrants in Sweden, regardless of the range, is relatively low compared to other European countries. However, a look at the proportion to the total population gives us a slightly different view. According to a crude calculation using the above figures from Baldwin-Edwards & Kraler and the total population of Sweden in 2010 as per Eurostat (Vasileva, 2011), irregular migrants in Sweden may represent between 0.2% and 0.9% of the total population. If we compare this figure to other European nations, we can reasonably state that the proportion is comparable to that of France, which has a similar range at 0.5%-0.8%. The calculation has been conducted using figures from the same sources. France however has a much higher estimate of absolute number of irregular migrants, ranging between 300,000 and 500,000 (Björngren Cuadra, 2010e). The *Clandestino* project (2009c) references the figures stated by the French Government in 2005 of between 200,000 and 400,000 irregular migrants, as well as a figure of 292,000 in 2006 calculated using a variety of *pressure* and *stay* indicators. The project is clear to note that the figures cannot be truthful owing to the challenges noted above.

The estimated number of irregular migrants in Norway stood at 18,000 as of 2006 (Zhang, 2008 cited in Oien & Sonsterudbråten, 2011). The figures present a proportion of irregular migrants to the total population of 0.39%, which was in line with the figures presented by the *Clandestino* Project. We can therefore place Norway alongside Sweden and France as States that have a medium population of irregular migrants in relationship to the other states in our analysis.

Baldwin-Edwards & Kraler (2009 cited in Björngren Cuadra, 2010b) put the estimate of irregular migrants in the Netherlands at 60,000-225,000, thus approximately 0.4%-1.4% of the total population of the country. Other figures cited by the *Clandestino* project are diverse. They include 60,000 in 2001, ranges from 64,000 to 128,000 irregular workers during the years of 1999 and 2008, as well as between 77,000 to 117,000 irregular residents between 2000 and 2005 (Clandestino, 2009b). While the *Nowhereland* project (Björngren Cuadra, 2010b) classifies the Netherlands as a country with a medium ration of irregular migrants in the European context, it might be argued that this is dependent on which end of the scale is considered. If we take the higher end of the estimate, representing 1.4% of the total population, the Netherlands might be considered a country with a high degree of irregular migrants.

Spain, a nation known for its general tolerance of irregularity, has both the highest absolute number and the highest proportion of the total population of irregular migrants amongst the countries covered in the analysis. It should nevertheless be noted that Spain also exhibits the widest scale of figures amongst all the six countries. According to Baldwin-Edwards & Kraler (2009 cited in Björngren Cuadra, 2010a), Spain had approximately 150,000 to 700,000 irregular migrants. Using those figures, the rudimentary estimate of the proportion of irregular migrants to the total population is between 0.3% and 1.5 %. Estimates referenced by the *Clandestino* project (2009a) range from 1.1 million as of July 2007 and a lower approximation of 419,000 as of January 2007 from another source, amongst others. Calculations from the *Padron* registry, in which irregular migrants must register in order to benefit from social services including health services, illustrate a significant decrease in irregular migrants since 2005 in Spain. Reasons being that 2005 saw the regularisation of approximately 570,000 irregular migrants (Gonzalez-Rodriquez, 2009), as well as the inclusion of Romania and Bulgaria in the EU in 2007, who had previously accounted for a good portion of the irregular migrants in Spain. The *Padron* figures[11] presented by *Clandestino* (2009a) show that there were approximately 1.2 million irregular migrants in Spain in 2005, while the number stood at an estimated 350,000 in 2008.

At the other end of the spectrum, Denmark has such a low estimate of irregular migrants that it is essentially insignificant in terms of the proportion to the total population. According to the rough approximation, irregular migrants represent 0.02-0.09% of the total Danish population, or approximately 1,000-5,000 in absolute numbers (Björngren Cuadra, 2010c).

In consideration of the above figures, what can they tell us about the relationship to the provision of health care services to irregular migrants? On the one hand, we may think that nations with a high proportion of irregular migrants might want to provide them with health care services. A large number of irregular migrants in a country might be an indication of their usage to society in terms of social and economic inputs, thus we might assume that the country is interested in having healthy and productive irregular migrants. At the same time, the country might recognize the potential impact on public health if such a high number of individuals were left out of the health care system. Alternatively, it might be argued that those with low proportions of irregular migrants might offer health services, as

[11] The *Padron* register may include a number of irregular migrants that have left the country without de-registering, thus the numbers are generally considered as inflated. Efforts to conduct re-registration have been undertaken, which also might have led to some irregular migrants being removed as the information regarding the update has not been widely communicated.

there would be little financial impact on national resources and visa versa. Otherwise, they may not offer services at all due to the fact that the population would be insignificant and/or overlooked.

The cases of Spain and the Netherlands, both countries categorized as providing *More than Minimum Rights*, exhibit a significant range in the proportion of irregular migrants to the total population. Conversely, Denmark, a country that provides *Minimum Rights* to health care services, has amongst the lowest number and proportion of irregular migrants in Europe. Sweden and Norway can be said to both have a medium proportion of irregular migrants to the total population and generally what would be considered a minimal to medium number in absolute terms, despite the difference between the two countries. Sweden, who is acknowledged as having the highest number of irregular migrants in Scandinavia, is the only country of the three to provide *Less than Minimum Rights* to health care as per the *NowHereland* categorization.

Aside from the difficulties of drawing comparisons due to the range of estimates and the inconsistencies of methodologies utilized, the numbers and proportions presented above still do not seem to indicate a definite relationship between the number of irregular migrants and health care policy. This conclusion is consistent with that of Cuadra (2011) in her examination of the same issue across all 27 EU member states. Nevertheless, the high absolute numbers of irregular migrants in Spain, in addition to France and the Netherlands to a lesser degree, may be an indication of a potential connection to health care policy. On their own, the numbers create some challenges, however linked with other factors they may in fact play a role in policy making regarding health services. Notwithstanding, the lack of more specific data makes it difficult to draw any significant conclusions.

8.2 Pathways to Irregularity

The difference of the primary pathways into irregularity may have an influence on a States stance regarding health care provision to irregular migrants. Overall, States' in which the primary pathways into irregularity are either unauthorized entry or overstaying for the purpose of economic activity seem to perceive the provision of health care in a more positive manner than those whose irregular migrant population is largely *produced* via the asylum process.

Irregular migration in the Scandinavian countries is principally made up of rejected asylum seekers (Harslof Hjelde, 2010). As indicated previously, Sweden received the fifth highest number of asylum applications amongst industrialized nations in 2011, whereas the USA remained the top asylum destination, followed by France (UNHCR, 2012). However, despite the fact that France receives the highest number of applications of any European country, the number of applications in proportion to the total population is not nearly as significant as in Sweden and Norway. As Table 2 on the next page indicates, over the 5 years period between 2007 and 2011, Sweden and Norway have received 15.6 and 11.7 asylum applications per 1,000 inhabitants respectively, whilst France has received only 3.3 applications per 1,000 inhabitants.

The recognition rates[12] for the Scandinavian countries are on the higher side as compared to France and Spain, despite the asylum policies of all three of the Scandinavian countries having reportedly become more restrictive over the last years; a shift that has been in conjunction with the broad-spectrum changes seen across Europe. At the same time though, both Sweden and Norway remain desired destination countries not only for their extension of the Geneva Refugee Convention to cover humanitarian and other protection but also for their asylum reception policies. Both nations operate a policy of normalization during the asylum process, in which they attempt to create conditions in preparation for integration of asylum seekers even at an early stage. Conversely, Denmark attempts to emphasize the temporality of the asylum process and offers restrictive services to asylum seekers. In Norway and Sweden, unlike a number of European nations including Denmark and France for instance, asylum seekers must not stay in 'waiting' centers but are free to live outside. There are also opportunities to work as well. Voluntary return of reject asylum seekers is encouraged, whilst bilateral agreements and incentives are also employed, otherwise enforced deportations are also utilized. All of which are in line with the EU Return Directive. However, the emphasis on voluntary return and reluctance to institute movement restrictions in both Sweden and Norway are believed to contribute to the possibilities for rejected asylum seekers to disappear (Bak Jorgensen & Meret, 2010).

Table 2: Number of Asylum Applications, Global Share, and Recognition Rates by Country

Country	No. Of Asylum Applications - 2011[1]	Share of Global Asylum Applications - 2011[1]	No. Of Asylum Applications per 1,000 Inhabitants[1]		Recognition Rates - 2010					
					First Instance[2]			Final Decisions[3]		
			2011	2007-2011	Total No. of decisions	Total No. of positive decisions	Positive decisions by %	Total No. of decisions	Total No. of positive decisions	Positive decisions by %
Sweden	29 650	7%	3.2	15.6	27 650	8 510	30,8%	12 830	1 250	9,7%
The Netherlands	11 590	3%	0.7	3.6	17 580	8 005	45,5%	1 350	675	50,0%
France	51 910	12%	0.8	3.3	37 610	5 095	13,5%	23 080	5 280	22,9%
Spain	3 410	1%	0.1	0.5	2 785	610	21,9%	1 545	15	1,0%
Denmark[4]	3 810	1%	0.7	3.0	3 280	1 345	41,0%	440	130	29,5%
Norway	9 050	2%	1.9	11.7	15 180	5 300	34,9%	10 100	410	4,1%

[1] United Nations High Commissioner for Refugees, 2012. Asylum Levels and Trends in Industrialized Countries: Statistical overview of asylum applications lodged in Europe and selected non-European countries [Online]. Available at: http://www.unhcr.se/fileadmin/user_upload/PDFdocuments/2012_News/AsylumTrends2011.pdf (accessed 15 April 2012)

2 Eurostat, 2010. Statistics Explained: First instance decisions (non-EU-27) asylum applications 2010 [Online]. Available at: http://epp.eurostat.ec.europa.eu/statistics_explained/index.php?title=File:First_instance_decisions_on_(non-EU-27)_asylum_applications,_2010_(number).png&filetimestamp=20111118152102 (accessed 3 May 2012)

[3] Eurostat, 2010. Statistics Explained: Final decisions on (non-EU-27) asylum applications 2010 [Online]. Available at: http://epp.eurostat.ec.europa.eu/statistics_explained/index.php?title=File:Final_decisions_on_(non-EU-27)_asylum_applications,_2010_(number).png&filetimestamp=20111118152029 (accessed 3 May 2012)

[4] Final Decisions data for Denmark from 2009

While rejected asylum seekers are measured as a significant group amongst irregular migrants in France and the Netherlands respectively, they do not make up the most substantial group in these countries (Björngren Cuadra, 2010b & 2010e). In France however, they are considered an increasingly important group. At present, the Netherlands

[12] Recognition rates are distinguished between first instance and final decision. First instance refers to the decision granted by the authorities responsible for the first instance of the administrative/judicial asylum procedure. The final decisions granted at the final instance of the administrative/judicial asylum procedure and from the appeal in which all normal routes of appeal have been exhausted.

receives a medium number of asylum applications as compared to other European nations[13], with the proportion of the applications to the total population similar to that of France. Asylum applications in the Netherlands were previously much higher, for example in 1998 there were more than 45,000 applications. However, increased restrictions in the asylum policy resulted in a significant drop, beginning from around 2003 (Eurostat, 2012). Despite this, the recognition rates in the Netherlands are higher than all of the five countries, both at first instance and final decisions. Nonetheless, it remains difficult to confirm the impact of the asylum process in *producing* irregular migrants in both countries.

Conversely, it can easily be ascertained that the role of the asylum process in *producing* irregular migrants in Spain is negligible. The Spanish Governments' policy of discouraging asylum has resulted in very low absolute numbers of applications, with only 0.5 applications per 1,000 inhabitants between 2007 and 2011 (UNHCR, 2012). Whilst the Eurostat (2010) figures note a decent recognition rate at first instance, approximately 22%, the final decision recognition rate is exceptionally small, at only 1%. Furthermore, the impact of the EUs first country of asylum policy implemented through the Dublin Regulation is believed to discourage asylum applications in Spain. This may also be linked to the fact that the aid offered to refugees in Spain is much more limited than in other European countries (Gonzalez-Enriquez, 2009). Even though Spain's restrictive asylum practices have raised concerns amongst human rights advocates, the issue remains only a small component of the country's immigration debate (Kreienbrink, 2008).

On the other hand, overstayers, individuals who previously held a valid permit, are considered to be the most noteworthy pathway into irregularity in both Spain and France, and a good part of those in the Netherlands (Björngren Cuadra, 2010a & 2010e). Illegal entry, once considered a major pathway in both Spain and France, is now much less significant as a result of improved border control mechanisms through the EU cooperation (Kreienbrink, 2008).

In Spain, the *befallen* irregular migrant, one who becomes irregular as a result of administrative issues and slow bureaucratic procedures, is believed to make up a large proportion of overstayers (Björngren Cuadra, 2010a). The recognition of the issue of the *befallen* by the Spanish public is often linked to the relatively positive view of irregular migrants in Spanish society as opposed to the wider European community. This may also be considered to impact State policies regarding irregular migrants.

The comparative analysis highlights that the countries that fall into the *Nowhereland's More than Minimum Rights* cluster, i.e. Spain, France and the Netherlands, all have irregular migrant populations where the primary pathway in irregularity is believed to be overstaying. On the contrary, the Scandinavian countries that are either placed in the *Minimum Rights* cluster or the *Less than Minimum Rights* cluster all have irregular migrant populations that are predominantly made up of rejected asylum seekers. According to Cuadra (2011), rejected asylum seekers are often left out from the norms of reciprocity within the EU countries, thus linking the importance of the type of irregular migrant to the welfare system. Rejected asylum seekers are often seen as a burden to the welfare state as they do not contribute to the system through engagement in the formal economy. It therefore gives the impression that the

[13] The range of asylum applications in Europe in 2011 ranged from around 52,000 applications in France to as little as 20 in Albania (UNHCR, 2012)

primary pathway to irregularity in a country interacts with other factors including the welfare state, the labour market and public opinion to influence health care policy. These other factors will be analyzed in more detail further on in the paper.

8.3 The Welfare State

In order to conduct the analysis of the role of the welfare state in regards to health care policy for irregular migrants, it is important to classify the welfare systems of each of our six countries. Esping-Andersen's Three Worlds of Welfare typologies can assist us in understanding the dynamics each of the relevant welfare states. Alternative classifications from other research in this field will also be sought for comparison as a means of gathering a comprehensive and current understanding.

Esping-Andersen classifies the Scandinavian countries together with the Netherlands as Social-Democratic welfare states (Arts & Gelisse, 2002). The Social-Democratic model is distinguished by a high level of de-commodification, as well as common benefits and equality. Social democracy is clearly the ideological background to this model (Esping-Andersen, 1990).

France is categorized in the Conservative model by Esping-Andersen. The model is characterized by moderate de-commodification, with social benefits depending highly on contributions and status (Arts & Gelisse, 2002). Furthermore, Conservative regimes also typically have a strong connection to the Church and an emphasis on family. Social insurance is generally linked to the breadwinner, thus promoting motherhood and a traditional family life. Services, such as child care, are normally underdeveloped (Esping-Andersen, 1990).

While Esping-Andersen has not categorized Spain, he has hinted in later works that Spain might be considered part of the Conservative model. Other researchers have proposed a separate model for the southern European nations; however Esping-Andersen has stated that they are simply underdeveloped versions of the Conservative models. He has drawn attention to the weak social protection systems, as well as the comparable connection with the Church and family life (Arts & Gelisse, 2002).

Castles & Mitchell offer a slightly different categorization by moving the Netherlands over to the Conservative group. In their definition, the Conservative grouping is typified by high social expenditures but few efforts at equality in social policy. On the other hand, they place the Scandinavian countries in what they call the Non-Right Hegemony group, which is described by high social expenditures with strong equalizing efforts (Arts & Gelisse, 2002).

Finally, in order to explore a classification that includes Spain as well, Ferrera's groupings are considered. Ferrera separates the states into Bismarck, Scandinavian and Southern welfare-state systems. The Bismarck group, which includes France and the Netherlands, includes a strong link between work status and benefits, relatively good social benefits largely financed through contributions, with the system primarily managed by unions and employers. The Scandinavian group, which clearly includes all three of our Scandinavian states of interest, is highlighted by universal

coverage, generous benefits mainly financed through fiscal revenue. Finally, Ferrera has created a specific grouping for the southern European states, including Spain. These welfare states are deemed characterized by some generous benefits yet without minimum social protection, a disjointed scheme of income assurances related to work position, financed via fiscal revenue as well as contributions, and health care as a right (Arts & Gelisse, 2002).

The criticisms of Esping-Andersen's work, as well as other classifications of welfare systems, centers around the rigid nature of the typologies. There is recognition that there are a number of States that do not fit within one of the three typologies, including Spain, whilst there is a general understanding that welfare systems are not static (Schubert et al, 2009). Recent literature points to the fact that France may actually be considered a hybrid system rather than purely Bismarckian. Although the path dependency theory holds true for the Scandinavian countries, albeit with a degree of reforms but nevertheless along the same ideological path, France is said to be moving away from its traditional path. It is stated it currently still remains fundamentally Bismarckian yet it has take on some aspects of universalism, such as universal benefits, as well as a disconnection between the employer and social protection. What's more is that there has been increased privatization of the welfare system, thus opening itself to the market and seemingly shifting to another of Esping-Andersen's typologies, Liberalism (Gallouj & Gallouj, 2009).

The Netherlands, having been classified as Conservative, or Bismarckian, by both Castles & Mitchell and Ferrera, and Social Democratic by Esping-Andersen, also appears to be difficult to precisely classify. Reforms have resulted in decreasing the covered population, as well as limiting benefits and privatization of schemes. The system puts the onus on the individual, however still maintains a means-tested safety net system (Oorschot, 2009). While it seems to generally fit with the Conservative model, it nonetheless has some features that are not a direct match.

What then can be said of the connection between the tradition and type of welfare system of a state to the provision of health care services for irregular migrants? It may be reasonable to assume that a country with a traditionally strong welfare state would be more likely to provide broader social services to irregular migrants than a country with a conventionally more limited welfare state. Then again, the evidence from our comparative analysis indicates that this is not the case.

The Scandinavian countries clearly comprise the most generous welfare states, with a strong emphasis on equality and the universality of benefits. Surprisingly though, these three states provide the least comprehensive services of our six countries for comparison. The reason for this is likely a result of the importance of the redistributive nature and the pro-work principle of the Social Democratic welfare system. In line with the position of the Swedish Government, it can be seen as unfair to provide services to individuals who do not contribute to the system (De Lomba, 2011). Irregular migrants, being mostly rejected asylum seekers, are not perceived as contributing to the welfare system because they cannot be engaged in the formal economy, even if they are employed. Whereas some argue that irregular migrants contribute to the growth of the economy, and subsequently the welfare system, this viewpoint does not seem to hold amongst politicians, policymakers and the general public in Scandinavia. Furthermore, there seems to be a fear of 'social tourism', which is reportedly unsubstantiated though not thoroughly tested as restrictions

remain. Scandinavians are proud of their welfare state and there is some concern that 'outsiders' may overwhelm the system.

On the other hand, the results point out that the states that are more difficult to quantify, either a hybrid or another welfare typology, are apparently more likely to accept a positive health care policy for irregular migrants. In line with the previous argument, it may again be relevant to consider the impact of financing. One feature that is similar between France and the Netherlands is that their welfare systems are insurance based. Furthermore, France and the Netherlands have tightened up the link between benefits and employment in recent years (Gallouj & Gallouj, 2009; Oorschot, 2009). Also, whereas Spain is a tax based health care system (Björgren Cuadra, 2011), the degree of inputs into the system are significantly smaller than in the Scandinavian countries. As a result, it could be argued that France, the Netherlands and Spain may not be as adverse to the provision of social services to irregular migrants. Nevertheless, the fact that irregular migrants are not generally expected to pay for health services in any of these countries, as the schemes are State funded, puts a flaw in the argument. The recent changes to the French *AME* scheme now required beneficiaries to pay a 30 € registration fee per year. The fee was introduced because the usage of the AME scheme increased, resulting in high costs that were deemed unacceptably high for the State to absorb (République Française, 2011). At the same time, the Dutch scheme notes that the cost should be paid by the patient. A state funded reimbursement can be sought by the private health care provider if the patient is not able to pay. In this regard, the appearance of a detachment between state funds to the scheme, or a belief that the resource requirements are minimal, may result in few concerns about the costs.

Despite this, the social spending-GDP ratio in 2005 indicates relatively similar figures for Sweden, France and Denmark, followed by the Netherlands with a significant fall to Spain. Also, the social spending per capita puts Sweden and Denmark just slightly higher than the Netherlands and France, with Spain considerably lagging behind (Bazant & Schubert, 2009). As such, the argument may hold true for Spain; however seems to be less strong in regards to France and the Netherlands. Additionally, Björngren Cuadra (2011) results from a wider comparative analysis do not indicate a connection between health care policy for irregular migrants and the types of financing system. Yet, the concept of economics of scale may be relevant to consider. Whereas France, for example, may more easily absorb the costs of few irregular migrants into their welfare system, Sweden on the other hand, with its much smaller population, may find the addition of few irregular migrants to be more of a strain on its system. The argument would hold true in comparison of the total populations of the states offering *More than Minimum Rights* and those offering *Minimum Rights* and *Less than Minimum Rights*. However, it remains difficult to draw any concrete conclusions. What can be considered relevant though are the views of the welfare system by politicians and policy makers, as well as the general public. As stated previously, the Scandinavians are very proud of their welfare system, hence the fears of 'social tourism' may be considered to weigh more heavily in these countries than the others.

Finally, it is also likely that the observed connection is not based solely on the welfare state but is rather a combination of a number of the factors, including number, type of irregular migrants and public opinion and the economic impact. Furthermore, the difficulties in categorizing three of our six countries has provided a set back to being able to provide

more concrete conclusions. Nevertheless, the logic of the limited health care provisions to irregular migrants in the Scandinavian countries indicates some relationship with the principles associated with the Social Democratic welfare system.

8.4 Immigration Policy

Bak Jorgensen and Meret (2010) note that previous studies have indicated that historical factors and customary migration networks are critical features influencing migration flows and asylum, as opposed to merely a liberal policy. More specifically to the interest of this paper, De Lomba (2011) makes the connection between States immigration policy objectives and health care provision to irregular migrants.

European States have considerably dissimilar histories of migration and immigration policy. France, Spain and the Netherlands all have a colonial past, along with a custom of offering special conditions for immigration from former colonies (Lavenex, 2009). However, Sweden, which can be linked with Norway and Denmark in this regard, is not a traditional immigration State. Immigration in the Scandinavian countries began only around the 1940s mostly with inter-Nordic labour migration and later followed with strong humanitarian based policies (Lundberg Lithman, 1987). In addition, whilst Spain did not attract much immigration prior to the 1980s, it now joins France as one of the main immigration destination in the EU. The Netherlands and Sweden follow with what can be said to be medium immigration figures, followed by Norway and then Denmark with the lowest immigration numbers in our grouping (Eurostat, 2012). The current form of immigration at the European level is highly heterogeneous (Lavenex, 2009), with differences in focus on labour migration, family reunification or asylum. Because of this, as Morehouse & Blomfield (2011) have noted, there are considerably different views of how to deal with irregular migration, and wider immigration policy for that matter. These variances are considered the chief challenge to the establishment of a common immigration policy in the EU (Lavenex, 2009).

Path dependency has made it politically difficult for colonial States to adjust existing immigration policies to institute increased limitations on migration from former colonies. While it has occurred, as in the Spanish example where visa restrictions were placed on Bolivians in 2008 as a means of addressing irregular migration (Gonzalez-Enriquez, 2009), the connections between former colonies and their respective colonial States remains strong. All three former colonial states indicate high numbers of the immigrant and foreign born populations originating from former colonies (Eurostat, 2011). Similarly, a look at the Scandinavian countries will illustrate a path of providing refuge for refugees and other persons in need of protection. Whilst the countries all imposed a degree of restrictions over time due to overwhelming numbers of asylum applications, the imposition of substantial restrictions were undertaken by Denmark alone in the early 2000s. Whereas Denmark chose to break away, for which they have suffered much criticism, Sweden and Norway remain on the path. The difficulties for Sweden are not ignored; however they have rather chosen a different channel in search of resolve. In line with game theory, where the players make moves to improve its status in relation to the current situation, one of Sweden's top priorities is to see the establishment of a common asylum policy so as to ease its burden through the distribution of responsibilities amongst all EU Member States.

The question remains, do immigration policies have a bearing on health care policy for irregular migrants? There are some identifiable connections between the States with a colonial past and those categorized in the *More than Minimum Rights*, and conversely those in the *Minimum Rights* and *Less than Minimum Rights* clusters with conventionally strong humanitarian approaches to immigration. Furthermore, States that are prime immigration destinations, including France and Spain, and to a lesser degree the Netherlands, are amongst the States that provide the most comprehensive health services to irregular migrants. Nevertheless, they are followed by Sweden, which is in the *Less than Minimum Rights* cluster, whereas the countries with the lowest numbers of immigration are Norway and Denmark, who are in the *Minimum Rights* cluster. As a result, there seems to be no clear connection between immigration policies and health care policy.

Nonetheless, discussing immigration policy as one solitary factor is simply not adequate. Immigration policies are complex and comprise a number of strategies underneath the heading. Two such features have been pointed out by Björgren Cuadra (2011) as potentially impacting health care policies for irregular migrants: control mechanisms and regularization. The paper will now consider a detailed analysis of the two factors in order to determine whether the assumption is well founded.

8.4.1 Control Mechanisms

In Cuadra's (2011) comparative analysis of the EU 27 member States health care policies in regards to irregular migrants, she notes that there is reason to believe that a State that operates more internal controls is more likely to have restrictive health care policies. An examination of our five countries of interest points to the fact that this may indeed be the case.

External control mechanisms refer to the control of the entry into a country, including border control mechanisms. Internal controls on the other hand relate to administrative procedures, counting the limiting of access to social benefits and public resources (Cuadra, 2011). The research indicates that all six of our countries of interest utilize high external control mechanisms, which is in line with the EU policy that seeks to 'fight illegal migration', citing security as one of the primary reasons (Carrera, & Guild, 2010).

In 2005, the EU established Frontex, the European Border Control Agency. The agency's scope has expanded since its inception, which is associated with supporting countries on the external borders of the EU that endure the majority of problem of irregular migration. This growth has also led to the criticism around the notion that the EU is building a 'Fortress Europe', becoming ever more restrictive towards Third Country Nationals (TCN)[14]. There is little doubt that heavy efforts have been placed towards external controls as part of the EUs collaboration regarding irregular migration (Lavenex, 2009).

[14] Third Country Nationals (TCN) refers to individuals who are not nationals of the EU country in which they currently reside nor are they a national from another EU Member State.

Internal controls seem to be where States differ. The Scandinavian countries operate high internal control mechanisms, whereas France and the Netherlands have moderate control levels, with Spain running moderate-low internal controls.

In regards to accommodation, an irregular migrant is likely to be faced with significant barriers to signing a rental agreement in any of the Scandinavian countries (Björngren Cuadra, 2010c & 2010d). In the Netherlands, agreements can be signed with landlords however there is doubt regarding the extent to which the documents would hold up in court owing to the irregularity of stay (Björngren Cuadra, 2010b). Irregular migrants in France are not actually able to sign legal contracts without documentation, however it is stated that it is done anyhow (Björngren Cuadra, 2010e). Finally, in Spain, irregular migrants are free to sign an accommodation lease (Björngren Cuadra, 2010a).

The ease of signing a lease in Spain is linked to the fact that irregular migrants in Spain register with the municipality (Björngren Cuadra, 2010a). Even in France, irregular migrants may register at the address of the local social service agency (Björngren Cuadra, 2010e). Restrictions related to a lack of official identification prove difficult to irregular migrants to access services in other countries. For example, without a Swedish personal number it is very difficult to access any basic service in Sweden (Baghir-Zada, 2009).

Children of irregular migrants have explicit legal rights to education in France, the Netherlands and Norway (Björngren Cuadra, 2010b & 2010e; Oien & Sonsterudbråten, 2011). In fact, the Norwegian legislation states that primary and lower secondary schooling is compulsory all children present in the country longer than three months. Irregular children may also easily access schooling in Spain, however they are not provided with a certificate demonstrating their completion. In Denmark there is no right to education, however much is left to the discretion of the schools and children may be enrolled on a case-by-case basis (Björngren Cuadra, 2010c). The same was previously true for Sweden; however a 2010 Inquiry recommended a change in legislation so as to ensure access to education for all children until secondary school (Björngren Cuadra, 2010d).

In all countries, irregular migrants do not have access to formal employment or social security (Björngren Cuadra, 2010a, 2010b, 2010c, 2010d, 2010e; Oien & Sonsterudbråten, 2011).

The examination of internal controls in particular illustrates that there are slightly more opportunities to access basic services for irregular migrants in the countries that offer *More than Minimum Rights*, with the exception of the education subject. The countries with *Minimum Rights* or *Less than Minimum Rights* are somewhat more restrictive. Notwithstanding, seeing as the divergence is not explicit, aside from Spain perhaps, it can be stated that the connection between internal controls and health care policies for irregular migrants is a relatively weak relationship on its own standing.

8.4.2 Regularization Policy

The comparative analysis of Sweden and the five other European nations' perception and usage of regularization programmes indicates that those countries that regularly utilize regularization programmes are more likely to offer comprehensive health care services to irregular migrants than those countries that use only regularization mechanisms on humanitarian basis only (Cuadra, 2011). Although, a nations' rejection of regularization in principle cannot be firmly linked to restrictive services for irregular migrants, as is evident with recent changes in the French position towards regularization.

Regularization, as the word itself suggests, is the process of regularizing the stay of an irregular migrant in the nation in which they have held an irregular status. Regularization programmes are a sort of one-off initiative that can be done on a large scale or with smaller numbers. A regularization mechanism allows for case-by-case decisions. Regularizations can target specific groups of irregular migrants, such as those active in the labour market, former asylum-seekers, or those that have remained in the country for a longer specified period of time. The State may choose to conduct a regularization exercise for a variety of reasons, including a need for a certain workforce, on a humanitarian basis, and/or related to public or political pressure, for example. Seeing that regularization programmes are usually conducted to target a specific group, a precise criteria is defined.

Of the states examined in the comparative analysis, both Spain and France have regularly utilized regularization programmes throughout the years. The finding of the REGINE study indicated that both Spain and France rely on such programmes (Cuadra, 2011). The Netherlands have made use of regularization programmes as well, however on a much smaller scale than both Spain and France. All three countries have utilized regularization programmes for both economic and humanitarian targets (Baldwin-Edwards & Kraler, 2009). Conversely, the Scandinavian countries in our analysis regularly only use regularization mechanisms, with few small targeted programmes on humanitarian basis.

Seeing as irregularity is considered the rule rather than the exception for migrants to Spain (Gonzalez-Enriquez, 2009), the fact that the Spanish government utilizes regularization programmes as a means of managing migration is hardly surprising. The logic behind the regularisations in Spain largely stem from the labour market as a means of tackling irregular employment. This is evidenced by the fact that the programmes have primarily targeted irregular workers. According to the *Nowhereland* project, approximately 1.2 million people have been regularized in Spain since 1986, with more than half being regularized after 2005 (Björngren Cuadra, 2010a). A mass extraordinary regularization in 2005 saw more than 570,000 people receive permits. The 2005 regularization, along with the expansion of the EU in 2007, is largely responsible for the sizeable decrease in the number of irregular migrants in Spain (Gonzalez-Enriquez, 2009).

The Spanish government attempted to restrict regularizations prior to 2005 as a means of curbing irregular migration, however it continued to grow. At the same time, as opposed to other European nations including France, there is support for regularization programmes amongst businesses, trade unions and NGOs in Spain (Gonzalez-Enriquez, 2009). This can be linked to the perception of irregular migrants, which again is in part related to the situation of the *befallen*,

where administrative procedures and slow processing result in irregularity. Only temporary permits are provided during regularization, although the evidence shows that the majority have been able to renew their permits in order to stabilize their residence (Arango & Finotelli, 2009).

France has conducted six regulation programmes since 1973, in which approximately 282,000 persons were regularized. The most recent programme was conducted in 2006, with an estimated 9,000 people being regularized, while another 80,000 or so were regularized during programmes in 1997, 1998 and 1999. Frances earlier programmes focused largely on irregular workers, whereas the more recent included family reunification or rejected asylum seekers, as was the case with the 2006 programme. The number of programmes has notably decreased over the years, with a shift towards a regularization mechanism rather than mass programmes. In addition, up until 2006, France provided an automatic regularization for those who had be residents for more than 10 years. This programme resulted in roughly 25,000 regularizations each year since the law was put in place in 1998 (Björngren Cuadra, 2010e).

The Netherlands has operated restrictive regularizations with only small numbers receiving permits. Government policies do not generally favour regularization; however the country conducted its most significant regularisation programme in 2007, where roughly 27,000 people received permits. Before then, four other programmes have taken place since 1975 (Bonjour et al, 2009). The regularization of 2007 was restricted to those who had applied for asylum, whereas a previous programme in 1995 specified employment as well as length of stay as the criteria (Björngren Cuadra, 2010b).

Regularization in Sweden is conducted on a case-by-case basis and is strongly associated with the asylum system. However, a temporary amendment to the Aliens Act in 2005 led to what could be considered Sweden's only regularization programme. The primary target was families with children who had established themselves throughout the long wait for a decision by the *Migrationsverket* (Swedish Migration Board). The programme saw approximately 17,000 rejected asylum seekers receive either a permanent (13,000) or temporary (4,000) permit out of approximately 31,000 applications (Kraler & Reichel, 2009). According to Kraler & Reichel (2009), regularization in Sweden appears to be used as a 'corrective instrument' and is utilized as a flexible tool to act in humanitarian situations.

According to the results of the REGINE project, the Danish government reports that two regularization programmes have taken place in Denmark, one in 1992 and another between 1999 and 2000. The first programme granted approximately 5,000 temporary permits to persons from the Former Republic of Yugoslavia on humanitarian basis. The second offered the same for persons from Kosovo; about 3,000 permits were provided during the time frame. The Danish Government does not view irregular migration to be a pressing issue, which is expected considering the low numbers of estimated irregular migrants in Denmark, therefore regularization is not a broad component of its immigration policy (Wöger, 2009).

According to Oien & Sonsterudbråten (2011), Norway does not have any regularization process. However, they noted that there was an ongoing debate regarding the issue with suggestions to adopt a regularization mechanism that could be utilized on a case-by-case basis.

While Spain still considers regularization as a key tool in managing irregular migration, as do other southern European nations, the northern European countries have publicly stated their opposition to mass regularization, including France. France, the Netherlands and Denmark, have all condemned regularization on the basis that it will promote irregular migration. They also intend to restrict labour migration generally. Sweden, who is also opposed to regularization programmes, gives a different motivation however. As Sweden has a generous open labour market policy as compared to many other European nations, it considers regularization programmes as unnecessary (Migration Policy Institute, 2011). The European Pact on Immigration and Asylum, adopted in 2008, set out a proposal to only use case-by-case regularization in EU countries as part of the larger programme to tackle irregular migration (Carrer & Guild, 2010). The issue of regularization remains a controversial issue amongst EU states.

The results of the comparison of the uses of regularization, including the target groups and to what extent, appears to suggest that there is a link between regularization and a State's willingness to provide health care services to irregular migrants. The countries that utilize regularization programmes are also those who provide the most comprehensive health services to irregular migrants. Spain, France and the Netherlands have all utilized regularization programmes and furthermore have done so for labour market reasons as well as humanitarian. Whilst France and the Netherlands have in recent years vocally opposed regularization, they have nevertheless actively used them in the past. The countries that provide more limited health services, Denmark, Norway and Sweden, seem vehemently opposed to labour market driven regularization programmes and mainly only use regularization mechanisms. However, while this argument seems to be supported at this point, the changing perception towards regularization may well see a significant decrease in regularization programmes in the future, thus proving difficult to make connections as exist now.

8.5 Economic Impact

In a publication for the Global Commission on International Migration, Koser (cited in Haidinger, 2007) stated that 'from an economic perspective irregular migration is actually quite functional for many destination states.' Düvell (cited in Haidinger, 2007) further makes the connection between the greater demand for a flexible labour force and irregular migration. He claims that the prospective for employment in a growing deregulated economy seems to qualify as a pull factor for irregular migration. De Lomba (2011) remarks that for all intents and purposes States rely on an irregular workforce as part of its general employment policies.

Hence, the hypothesis presumes that States who perceive irregular migrants as economically beneficial are likely to be more willing to afford them access to social services, including health care. In relation to this, the primary economic sectors linked to the shadow economy and irregular migration are sectors that tend to be more significant and labour intensive in the countries that provide higher levels of health services to irregular migrants, such as agriculture and

construction for instance. Furthermore, it is assumed that the degree of labour market controls and the overall political climate towards irregular migrant workers has an impact on the States' health care policy.

As specific figures regarding the irregular migrant worker community remain limited, the available data will be examined together with a look at data from the shadow economy, also called the informal economy (Schneider & Enste, 2002), as well as the primary sectors of employment for migrant workers. Table 3 shows the economic sectors in which foreign populations are employed, whilst Table 4 includes data regarding the size of the economic sector, and Table 5 illustrates the size of the labour force by economic sector. It should be noted that the data has been extracted from different sources and the categorization of sectors varies slightly, thus limiting the possibility of a direct correlation of the data. Furthermore, no data was available for the Netherlands regarding migrant employment. Regardless, it is expected that these areas combined can assist in scrutinizing the relevance of the role of irregular migrants in the national economy, therefore allowing the evaluation of a relation to a State's readiness to accord health services to irregular migrants within its borders.

8.5.1 Economic Sectors

As Table 3 indicates, the primary sectors of employment of regularized migrants are comparable to the sectors that are generally acknowledged as providing employment to irregular migrants, as well as in the shadow economy (Haidinger, 2007). The sectors of agriculture, construction, manufacturing and services are conducive to both the shadow economy and irregular migrant employment, as they are often considered lower paid, lower status jobs that are found in small firms or self-employment (Toksöz, 2007). As Schierup (2007) affirms, these types of jobs are easier to maneuver around regulations, whereas larger firms have more difficulties because of stricter state controls, bureaucratic practices, and trade union monitoring, for example.

The data in Table 4 illustrates that the agricultural sector in Spain makes up a larger share of percentage of the GDP than the other countries, at 2.5%. Furthermore, both Spain and France indicate high total percentages of employment in the agricultural section, with 4.2% and 3.8% respectively, as well as large numbers of migrants employed in the agricultural sector, at 4.6% and 4.2% correspondingly. Information for both countries indicates the agriculture sector as a chief sector of employment of irregular migrants, though much more significantly in Spain (Clandestino, 2009a & 2009c). In fact, the agricultural sector has been noted as a primary entry point into the job market for irregular migrants, with 15% of applicants in the 2005 regularization programme in Spain having been employed in that sector. In Spain in particular, employers have indicated that the difficulties in recruitment of regularized workers has led to the need to hire irregular migrants (Clandestino, 2009a). Though not as apparent from the data presented above, studies in the Netherlands (Van der Leun & Kloosterman, 2006; Visser & van Zevenbergen, 2011 cited in Clandestino, 2009b) point to the horticultural and agricultural sectors as the largest employers of irregular migrants. Though indicating slightly different results, with the construction and catering sectors coming out as more significant than agriculture, a 2005 study nevertheless showed that around 20% of all Dutch horticultural and agricultural employers hired irregular migrants (Clandestino, 2009b).

In comparison to Sweden, it is suspected that the type of agricultural economy has an impact on the employment of irregular migrants. For instance, the production of grapes and fruit in Spain is much more labour intensive than producing the chief crops of Sweden, which are grains. The Netherlands and France produce both grains as well as fruits, thus it is considered slightly less labour intensive than in Spain, yet remains notable (CIA, 2012).

Table 3: Employed Persons by Economic Sector, Total and Migrant Population

Country	Sweden		The		France		Spain		Denmark		Norway	
Economic Sector	***2001***		***Data***		***2000***		***2002***		***2001***		***2001***	
A - Agriculture, Hunting & Forestry	Total 73 984		Total N/A		Total 929 820		Total 897 900		Total 98 911		Total 83 774	
	Migrant 1 221	1,7%	Migrant N/A		Migrant 39 359	4,2%	Migrant 41 000	4,6%	Migrant 3 277	3,3%	Migrant 1 173	1,4%
C - Mining & Quarrying	Total 7 088		Total N/A		Total N/A		Total 61 500		Total 3 095		Total 31 756	
	Migrant 141	2,0%	Migrant N/A		Migrant N/A		Migrant 2 600	4,2%	Migrant 67	2,2%	Migrant 1 848	5,8%
D - Manufacturing	Total 713 803		Total N/A		Total 4 119 607		Total 2 937 000		Total 447 010		Total 281 958	
	Migrant 35 613	5,0%	Migrant N/A		Migrant 216 934	5,3%	Migrant 66 400	2,3%	Migrant 17 088	3,8%	Migrant 13 161	4,7%
F - Construction	Total 230 655		Total N/A		Total 1 245 619		Total 1 850 800		Total 171 567		Total 147 262	
	Migrant 5 926	2,6%	Migrant N/A		Migrant 207 217	16,6%	Migrant 92 700	5,0%	Migrant 2 657	1,5%	Migrant 4 726	3,2%
G - Wholesale & Retail Trade; Repair Motor Vehicles, Motorcycles, Personal & Household Goods	Total 470 834		Total N/A		Total N/A		Total 2 526 400		Total 408 267		Total 326 394	
	Migrant 16 706	3,5%	Migrant N/A		Migrant N/A		Migrant 58 900	2,3%	Migrant 11 872	2,9%	Migrant 11 951	3,7%
H - Hotels & Restaurants	Total 90 893		Total N/A		Total 15 976 121		Total 950 900		Total 70 652		Total 68 407	
	Migrant 11 071	12,2%	Migrant N/A		Migrant 785 572	4,9%	Migrant 74 900	7,9%	Migrant 8 371	11,8%	Migrant 10 332	15,1%
O - Other Community, Social &Personal Service Activities	Total 2 320 243		Total N/A		Total 7 662		Total 6 616 100		Total 1 457 247		Total 1 215 547	
	Migrant 100 204	4,3%	Migrant N/A		Migrant 686	9,0%	Migrant 187 100	2,8%	Migrant 45 584	3,1%	Migrant 61 845	5,1%
Total Employed Migrants - all sectors	**133 907**		**N/A**		**1 249 768**		**523 600**		**88 916**		**105 036**	

Data from ILO International Labour Migration Statistics LABORSTA Internet [Online]. Available at: http://laborsta.ilo.org/ (accessed 24 April 2012)

Table 4: Total Percentage of GDP by Economic Sector by Country

Country	*Date of Data*	GDP (100%)	Percentage of GDP				
			Agriculture, hunting and forestry, fishing	Manufacturing	Construction	Wholesale and Retail Trade; Repairs, hotels and restaurants, transport	Other Service Activities
Sweden	***2010***	3 330 581,0	1,6%	14,2%	4,8%	16,9%	23,7%
The Netherlands	***2010***	588 414,0	1,8%	11,9%	4,8%	18,4%	23,5%
France	***2009***	1 889 231,0	1,6%	9,7%	5,9%	17,3%	24,3%
Spain	***2009***	1 047 831,0	2,5%	11,8%	10,1%	23,0%	21,5%
Denmark	***2010***	1 754 648,0	1,0%	10,5%	3,7%	17,7%	25,0%
Norway	***2010***	2 523 226,0	1,4%	8,2%	4,3%	13,5%	20,1%

OECD StatsExtracts, 2012. Gross Domestic Product [Online]. Available at: http://stats.oecd.org/Index.aspx?datasetcode=SNA_TABLE1 (accessed 03 May 2012)

Table 5: Total Percentage of Labour Force by Occupation by Country

Country	*Date of Data*	Labour Force by Occupation		
		Agriculture[1]	Industry[2]	Services[3]
Sweden	***2008***	1.1%	28.2%	70.7%
The Netherlands	***2005***	2,0%	18,0%	80,0%
France	***2005***	3.8%	24.3%	71.8%
Spain	***2009***	4.2%	24,0%	71.7%
Denmark	***2011***	2.6%	20.3%	77.1%
Norway	***2008***	2.9%	21.1%	76,0%

Source: CIA World Factbook, 2012. Labour Force by Occupation [Online]. Available at: https://www.cia.gov/library/publications/the-world-factbook/fields/2048.html#no (accessed 17 May 2012)

[1] Includes farming, fishing and forestry

[2] Includes mining, manufacturing, energy production and construction

[3] Includes government activities, communications, transport, finance and all other economic activities that do not produce material goods

Another sector of interest is the construction sector. According to the figures presented in Table 4, Spain has a much higher percentage share of the GDP in construction, at 10.1%, with the next highest being France, at 5.9%. Again, the fact that the jobs consist of manual labour and are temporary makes them less attractive to nationals and easier for irregular migrants to take up. Information from Spain has indicated that irregular migrants make up a notable proportion of this sector, which is again confirmed through figures from the 2005 regularization programme which showed that 21% worked in construction (Clandestino, 2009a). Furthermore, labour inspections in France found that most infractions of employment of irregular migrants were found in the construction sector (European Migration Network, 2011). The Dutch Ministry of Social Affairs and Employment moreover identified construction as another risk sector for employment of irregular migrants and a 2005 study indicated that 28% of construction firms employed irregular migrants (Clandestino, 2009b). At the same time, it is expected that this sector makes up a proportion of the shadow economy in the Scandinavian countries. However, as will be discussed later, it is unlikely to employ as large a number of the proportion of irregular migrants as in the above countries but instead rather nationals attempting to avoid tax payments.

The services sector, including personal and community service activities, employs the largest numbers of regularized migrants in all countries with the exception of France, in addition to making up large proportions of the labour force and the share of the GDP. Furthermore, the employment of irregular migrants in this sector has been confirmed in all countries, albeit to differing degrees.

All of the above mentioned sectors are considered to be more easily manoeuvred due to the fact that there are few labour controls, employment involves small firms or self-employment, and the positions are usually temporary. This is consistent with Schierup's earlier point. Notwithstanding, it is difficult to make a concrete analysis of the economic sectors as there is no definitive data on employment of irregular migrants. Additionally, the available data can only offer indications, plus the variances in the categorizations of the data make it even more challenging.

8.5.2 Shadow economy

The shadow economy can be defined as 'all market-based legal production of goods and services that are deliberately concealed from public authorities...' to avoid payment of taxes and social security inputs, labour market standards, and/or meet the necessary administrative terms (Buehn & Schneider, 2012). It can involve both workers who take on a second job, as well as those who work only in the shadow economy; either because of profitability or a lack of a legal work permits (Schneider & Enste, 2002). As such, irregular migrants make up only part of the shadow economy, and the scale of their make up in relation to those with a regularized status is unknown. Williams and Windebank, as well as Samers (cited in Schneider & Enste, 2002) claim that citizens make up the majority of those working in the informal labour force, and Schneider and Enste (2002) also state that informal work chiefly benefits those already in employment. Martinez Viega (2007) nevertheless asserts that we cannot ignore the connection between informal work and irregular migration. In fact, the differences amongst the countries in our comparative analysis deserve attention in this regard.

The figures presented in Buehn and Schneider (2012) in Table 6 below indicate that Spain's shadow economy is slightly larger than that of the other five countries in our analysis, at about 22.5% on average between 1999 and 2007. The Scandinavian countries follow, with similar figures around 18%, while France and the Netherlands present lower figures, with an average of 15% and 13% respectively between 1999 and 2007.

Table 6: Size and Trend of shadow economy in percentage of GDP by Country

Country	1999	2000	2001	2002	2003	2004	2005	2006	2007	Country Av.
Sweden	19.6	19.2	19.1	19.0	18.7	18.5	18.6	18.2	17.9	18.8
The Netherlands	13.3	13.1	13.1	13.2	13.3	13.2	13.2	13.2	13.0	13.2
France	15.7	15.2	15.0	15.1	15.0	14.9	14.8	14.8	14.7	15.0
Spain	23.0	22.7	22.4	22.4	22.4	22.5	22.4	22.4	22.2	22.5
Denmark	18.4	18.0	18.0	18.0	18.0	17.8	17.6	17.0	16.9	17.7
Norway	19.2	19.1	19.0	19.0	19.0	18.5	18.5	18.2	18.0	18.7

Source: Reproduced from Buehn, A. and Schneider, F., 2012. Shadow economies around the world: novel insights, accepted knowledge, and new estimates. International Tax and Public Finance, 19, 139–171

The figures indicate that all of the countries have experienced a slight decrease in the shadow economy throughout the years from 1999 to 2007. The results can be said to be linked in part to increased efforts towards curbing irregular migration and improved labour market inspections in all of our countries for analysis, along with the economic climate. The Employers' Sanction Directive (2009/52/EC), which prohibits the employment of irregular migrants and establishes minimum standards of penalties for employers of irregular migrants, is binding for all of the countries with the exception of Norway (European Migration Network, 2011).

According to Toksöz (2007), shadow economies are commonly larger in countries where the welfare state is more limited, while it remains marginal in countries that offer more comprehensive welfare provision. Furthermore, it is believed that states with stricter labour market regulations are more likely to have marginal or low shadow economies, as there is less room to divert from the regular. This seems to be correct in regards to Spain, France and the Netherlands, however it does not account for the Scandinavian countries. Contrarily, another view is that State regulations, such as working hours and wages, can actually support the growth of the shadow economy as they have a bearing on costs of doing business (Schneider & Enste, 2012). This explanation seems plausible in regards to the Scandinavian countries. Overall however, the discrepancy exemplifies the results of recent research that has pointed to the fact that the nature of the shadow economy cannot be explained by mono-causal explanations but is rather a more complicated interplay of factors, including economic, social and cultural (Williams, 2010).

In Spain, the shadow economy is viewed as a pathway into regularization. Martinez Veiga (2007) notes that Spain's migratory regime is inherently different to others in that the bulk of migrants who enter do so without papers and are regularized at a later time. For this reason, the informal economy in Spain is considered to be a major pull factor for irregular migrants. There are few incentives for engagement in the formal economy when a general tolerance towards both the informal economy and irregular migrants exist at both the level of government and the general population. In fact, the informal economy has even been pointed to as part of the explanation as to why asylum applications are so

low in Spain; the opportunities for employment in the irregular economy are more appealing than the safeguards offered to asylum seekers and refugees (Gonzalez-Enriquez, 2009). As noted earlier, Spain neither has a comprehensive welfare system nor does it have strong labour market regulations, both of which have been linked to the size of the shadow economy. A shadow economy is therefore more likely to thrive in comparison to France or the Netherlands, for instance, who have a more negative viewpoint towards the shadow economy in general and stricter regulations.

In France, the shadow economy is assumed to feed irregular migration (European Migration Network, 2011). As such, stricter restrictions in line with the Employers' Sanction Directive (2009/52/EC) have been eagerly implemented. France's shadow economy is on the lower side as compared to the other five countries, with 15% on average. However despite an increase in labour inspections, the informal economy in France is nevertheless stated to be thriving, with a number of economic sectors still actively hiring irregular migrants, including construction, public works, catering, hotels and personal services (Clandestino, 2009a), which is consistent with figures presented above.

Similar circumstances have been reported in the Netherlands. The shadow economy is reported as the smallest amongst our six countries, at 13.2% on average between 1999 and 2007. The Ministry of Social Affairs and Employment noted that the construction, agriculture, horticultural and catering sectors were the worst offenders in the employment of irregular migrants. An acknowledgment by the Government of the challenges in recruitment for such sectors resulted in a scheme to more easily assist employers to legally engage foreign workers for temporary positions. It is believed that this scheme has had an impact in reducing the employment of irregular migrants in these sectors; however they still remain the primary employers of irregular migrants (Clandestino, 2009b).

Conversely, the situation in the Scandinavian countries seems to differ. Whilst the percentage of the shadow economy towards to the overall GDP in Sweden, Norway and Denmark is relatively high, around 18% on average, it is believed that the proportion of irregular migrant workers in the shadow economy is much less than those in France, Spain and the Netherlands. According to Schneider (Schneider, 2002), research has shown that the driving force of the shadow economy in the Scandinavian countries is linked to the direct tax burden. The larger the divergence between the total cost of labour in the formal economy and the after tax earning gives more incentives to work outside of the formal economy. It might be considered costly for private citizens to engage private labour services, such as construction, plumbing and electrical, and cleaning for example, therefore much of this type of employment may be undertaken through the 'black' market. The social security system in the Scandinavian countries may also contribute to the growth of the informal economy, as many individuals are said to seek methods to avoid paying high taxes and increase their take-home earnings as a result. As such, the linkage of taxes and social security contributions are stated as key factors leading to the growth of the shadow economy furthermore supports the argument that a high percentage of the shadow economy is comprised of regularized residents.

Further, information indicates that the entry into the informal economy in Scandinavian countries may be less likely because of the type of irregular migrants in these countries, i.e. rejected asylum seekers. A study conducted amongst irregular migrants in Norway by Fafo (Oien & Sonsterudbråten, 2011) indicates that rejected asylum seekers are

reluctant to engage in the shadow economy for fears of future repercussions on their asylum process. It was noted that despite not wanting to engage in 'illegal' activity, entry into the shadow economy eventually becomes a necessity; however unlike our other three countries of interest economic endeavours do not seem to be the primary driver amongst irregular migrants in Scandinavia. The hidden nature of this group makes it more difficult for them to seek out employment. Rejected asylum seekers are most often without any forms of official documentation. It has been suggested that the primary pathway into the shadow economy for irregular migrants in Scandinavia is via networks, such as friends and family and people from the similar region. Jobs might include cleaning or other domestic services (Oien & Sonsterudbråten, 2011). Furthermore, information from the *Skatteverket* (Swedish Tax authorities) indicates that a large proportion of the shadow economy is linked to micro-businesses (Skatteverket, n.d). It is expected that developing business networks to enter into such businesses is quite challenging for irregular migrants, at least at the beginning, as was confirmed by irregular migrants in the Fafo survey (Oien & Sonsterudbråten, 2011). These factors, coupled with the Scandinavian states' lack of tolerance for the irregular economy and irregular migration in principle, may factor in to the relatively high irregular economy yet negative view of it.

The data shows that while Spain has the largest shadow economy, it also has higher percentages of the GDP and workforce related to economic sectors that are linked to the shadow economy. More specifically, it has been stated that the shadow economy is made up of large numbers of irregular migrant workers. On the other hand, while a good proportion of the shadow economies in France and the Netherlands has been linked to irregular migration, the size of the economies are the lowest amongst our grouping. The Scandinavian countries however indicate significant shadow economies, yet the workforce is largely thought to be regularized residents as opposed to irregular migrants. It therefore appears that the countries that offer *More than Minimum Rights* to irregular migrants in terms of health care all have shadow economies with larger proportions of irregular migrant workers, though not necessarily larger shadow economies. On the other hand, the countries that offer *Minimum Rights* and *Less than Minimum Rights* are believed to have shadow economies that have lower proportion of irregular migrants. In this sense, there appears to be a linkage.

However, it is likely that any linkage is more complicated and involves a variety of interrelated factors; including the perceptions of the shadow economy and control mechanisms. Spain, with its highly de-regularized economy could be said to acknowledge the importance of the irregular labour force to its economy and subsequently ensures basic social services for those in an irregular situation in the country. On the other hand, as has been mentioned previously, the Swedish government remains resolved in its view that the irregular economy is a breeding ground for exploitation and the provision of social services to irregular migrants might encourage those in an irregular situation to remain in the country in an extremely vulnerable position. The same could be said for Norway and Denmark, and to a lesser degree France and the Netherlands. Therefore, what can be said is that the perception of the government and the general public in this regard seems to have a strong bearing on social service provision, including health care.

8.6 Public Opinion

Sweden, just as the other five states of interest, is a democratic nation. A democracy directed by the will of the people and managed by a majority rule. Public opinion directly influences public policy. Politics is everywhere and the need

for politicians to appease the public cannot be overlooked in relation to the potential impact on our discussion. Consequently, the perception of irregular migrants amongst the general population looks as if it can act as a significant factor in determining the health care policy in a country. In fact, it is a cross-cutting factor that has presented itself as relevant to the discussions of all of the previously discussed factors as well.

'Few areas of public policy are subject to greater misrepresentation in public and political discourse, yet more influenced by public opinion, than international migration.' (IOM, 2011)

Public opinion highly influences public policy both domestically and regionally (Gonzalez-Enriquez, 2009). Opinions about immigration are shaped by both contextual factors as well as the political discourse. At times of economic recession or during political turmoil, for instance, attitudes towards immigration tend to become more negative ensuing increased calls for restrictive immigration measures. At the same time, stakeholders play a primary role in shaping opinions, including trade unions, civil society, government and political parties, as well as the media (IOM, 2011).

According to Gonzalez-Enriquez (2009) there is a strong impact of the media on the development of perceptions of irregular migrants within the general population. While the IOM World Migration Report (2011) notes that a direct causal link between media coverage and its influence on public opinion or policies cannot be affirmed, it acknowledges that the media significantly influences attitudes. It is noted that the media is most often the primary, if not the only, source of information on immigration that reaches the general public. As such, the manner in which the media frames the debate can have an important effect on public perceptions of migrants.

As regards to the potential impact of public opinion, Spain provides us with a good example. Immigrants in Spain are generally positively perceived as opposed to other European nations, including France, Sweden and our other countries of interest to our analysis. Furthermore, Gonzalez-Enriquez (2009) points to a traditional lenience towards illegality rooted in the southern European political culture as a measure as to the views towards irregular migrants. Internal control mechanisms, such as raids and mass expulsion are utilized in a number of countries as a tool for managing irregular migration; however this type of activity in Spain is likely to be negatively received by the public. As such, the Spain Government does not actively engage in such strong measures. Furthermore, as opposed to other European nations, it is stated that irregular migrants are almost never reported by private citizens. The general public's acknowledgement of the challenges associated with migration in Spain, including slow processing and changes to the legal framework, have resulted in an understanding that the Government bears some responsibility for the high irregularity in Spain.

Furthermore, as stated previously, stakeholders can have a critical impact on the debate as well. According to PICUM (2010), civil society can effect change in immigration policies. The example used to illustrate their statement comes from Sweden, where the *Vårdförbundet*, Sweden's National Assembly of Health Professionals, has publicly denounced Sweden's unwillingness to provide equal health services to irregular migrants as to regularized residents. They have

argued that the legislation contradicts medical professional ethics. The *Vårdförbundet,* together with criticisms brought forth by a number of NGOs and human rights agencies, seems to have made an impact on the Swedish Government. An Inquiry on the topic of health care for irregular migrants was established by the Government which released a report in 2011 (Swedish Office of Administrative Affairs, 2011) stating a recommended change in the legislation to take effect as of January 1st, 2013. One of the reasons stated for the change was the ethical issue brought forth by the *Vårdförbundet*.

The Swedish Government's apparent adjustment of its position regarding the provision of health services to irregular migrants is a fitting place to close this chapter. After much condemnation from civil society at a national level, along with international criticism from the United Nations, the Swedish Government appears to be willing to appease it critics. The *shame game* may have perhaps had a degree of success, albeit to what extent is not yet known.

CONCLUSION

The Swedish Government remains reluctant to address the issue of health care services for irregular migrants, even as it has openly acknowledged the extreme vulnerability of the group. Whereas there have been a number of efforts by civil society and the UN to bring the issue to the forefront through use of the *shame game,* to which there has been a degree of success such as the commissioning of the Inquiry on the issue, irregular migrants continue to elude the attention of the generous Swedish welfare state. The response to the Inquiry report, which suggests an alteration to the existing policy framework, has not yet translated into noteworthy efforts towards change.

The nature of irregular migration continues to pose serious concerns for our understanding of the universality of international human rights. Whereas the question of the right to health for irregular migrants is not likely to be disputed on moral grounds, it nevertheless presents a challenge to the principle of sovereign nation rights and a conundrum to State's experiencing negative sentiments on immigration amongst their constituents. The lack of a consistent and meticulous definition of health and the right to health presents a further dilemma in regards to State obligations. The analysis of the international human rights documents indicates that the right to health in the legislation is rarely qualified. The expansion of interpretations is instead conducted outside of the legally binding documents, mostly in general comments or statements, thus leaving room for divergences. Clearly, the lack of detail in the UN international human rights conventions is a result of the need to appease a large number of State actors, thus resulting in diluted rights in exchange for ratification. The European level obligations are nevertheless more restrictive in terms of service levels, yet less easy from which to diverge.

In consideration of the above, the examination of the legal obligations of the Swedish Government towards the provision of health care services to irregular migrants is technically limited to emergency services, as outlined in the European legislation. As the Sweden's domestic legislation indicates that non-residents are entitled to 'immediate' health care services, it can be concluded that Sweden meets its legal obligations. Criticism of the accessibility of said services remains a challenge; however the issue goes beyond the scope of this paper.

A number of factors potentially affecting health care policies for irregular migrants have been evaluated. The overarching result indicates that the factors cannot stand on their own, but are instead highly interactive. Just as Williams (2010) noted with the shadow economy, that it could not be explained by mono-causal explanations, neither can the factors affecting policy. Decisions are based on an interplay of economic, social and cultural aspects; some to a higher degree than others. As a result of this, alongside the variations amongst States, it remains difficult to derive any concrete conclusions as to the extent of the impact.

The examination of the size of the irregular migrant population by state indicates that there is no real relationship in regards to health care policy. Sweden, which has a higher number of irregular migrants than both Denmark and Norway, offers fewer services. Aside from that however, it is believed that the numbers factor may present itself as relevant in collaboration with other factors, especially where high numbers are concerned.

The pathways into irregularity appear to suggest a relationship with health care policy decisions, albeit in connection with other factors. For instance, the Scandinavian countries irregular migrant population is largely made up of rejected asylum seekers. As noted earlier, the strong redistributive character of the Social Democratic welfare system with its emphasis on pro-work does not seem to be conducive with this type of irregular migrant population. On the other hand, overstayers, which are the primary pathway into irregularity in Spain and France and a large group in the Netherlands, are reported to make up significant proportions of the shadow economy as irregular migrant workers.

The role of the welfare systems in France and the Netherlands is slightly more difficult to quantify as a result of the challenges of the variety of classifications of their systems. The results seem to point to the fact that insurance based systems are more likely to be conducive to more comprehensive health services for irregular migrants, however the argument is refuted in that the health care schemes for irregular migrants in these states are state funded, as is the Spanish welfare system. As such, the importance of the welfare state to the Scandinavian countries in this regard seems to be highly related to public opinion.

The historical and current nature of immigration and immigration policy furthermore seems to impact a state's position. Spain, France and the Netherlands are all countries with a colonial past, whereas Denmark, Norway and Sweden have largely remained homogenous until the mid-1900s and are not traditionally immigration nations. The former furthermore make up significant immigration destinations at this time, with Sweden following to a lesser degree. Nevertheless, it would be unreliable to claim any direct relationship to health care policies for irregular migrants based on these factors. Immigration history and policy is complex and wide-ranging, thus it has been deemed better to examine specific factors within the policies that may prove relevant.

The levels of internal controls and usage of regularisation has demonstrated links to health care policy. Whereas the Scandinavian countries exhibit high internal controls, with irregular migrants necessitating a hidden lifestyle, the French and Dutch operate only moderate internal controls. Spain's internal controls are categorized as moderate-low, yet

even where controls exist there is a lack of enforcement that creates a relatively free environment for irregular migrants to live.

At the same time, Spain is a proponent of regularization programmes, having used them extensively as a tool for managing irregular migration. The results showed that France and the Netherlands have also utilized such programmes; nevertheless they now remain opposed to them. All three countries used programmes for economic reasons. The Scandinavian countries nevertheless generally only used regularization for humanitarian purposes.

The differences in internal controls and regularizations indicate clearly the policy directions of the states of interest. The results show that while the Scandinavian countries, as well as France and the Netherlands, are adamant regarding their principle that irregular migration is an affront to sovereign nation rights to control the entry and stay, whereas Spain clearly displays a general tolerance towards irregular migrants.

Whereas the figures regarding the role of irregular migrants in the shadow economy remain limited, the results of the analysis nevertheless point to the fact that States with a good proportion of irregular migrants involved in the shadow economy may be more likely to provide them with health care. The linkage has been made between irregular migrant employment and sectors that are conducive to the shadow economy, such as construction, agriculture and services. The jobs are unattractive to nationals, including the fact that they tend to be temporary, low paying, and involve long hours, in addition to being more complicated to regulate. On the other hand, it is assumed that the irregular migrants in Scandinavia enter the shadow economy less easily as a result of lack of opportunities as well as fears of compromising their asylum process and fears of deportation.

Finally, public opinion has proved to be a factor of great important that is cross-cutting across all other factors. The overall perception of irregular migration by the general public, the media, politicians and policy makers in particular, appears to have an immense impact on a state's standpoint regarding irregular migration, and subsequently health care policy for irregular migrants. The role of a state's immigration history, whether it is has a traditionally strong or traditionally weak immigration history, can also be considered to have an impact on the overall public opinion regarding irregular migration within the general population of a state.

Regardless of the apparent linkages between the observed factors and a State's health care policy towards irregular migrants, it must again be highlighted that the challenges related to the study of irregular migration in the lack of available data and information, together with the ever changing nature of the situation, makes it problematic to affirm definite findings.

In conclusion, the application of game theory may assist us in understanding the ongoing shifting opinion of the Swedish Government towards the provision of health services to irregular migrants. The current political and economic climate, with calls for increased restrictions on immigration in general and irregular migration in particular, from a component of the general voting public along with the EU support the existing standpoint. At the same time, while the

EU is promoting a 'fight' against irregular migration generally, a number of prominent EU states exhibit support for health care services for irregular migrants, including France for example. Nevertheless, the consistent denunciation of the Swedish Governments position by civil society, the UN and a proportion of the voting public seems to be putting pressure on the Government's standpoint. Sweden is proud of its international reputation for human rights and its welfare system, thus the *shame game* has a particular impact on its decision making. Nevertheless, the existing fears of 'social tourism' and increasing irregular migration remain at the heart of the Swedish Governments restrictive position. While it is likely that the inquiry's suggestion will eventually be addressed, the extent to which is not known. As game theory indicates, the player may make concessions but the overall point is to reach its goal. As such, it can be expected that the Swedish Government is unlikely to verge away completely from its original path. The fact remains that irregular migrants continue to represent an affront to principle of national sovereignty.

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